Third Party Liability Department

TPL Operating Procedures – Volume III

LIBRARY REFERENCE NUMBER: CLTP10001 – Volume III DATE: DECEMBER 2004 VERSION 3.0

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INDIANA HEALTH COVERAGE PROGRAMS

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Document Management System Reference: TPL Operating Procedures – Volume III

Address any comments concerning the contents of this manual to:

EDS Document Management Unit
950 North Meridian Street, Suite 1150
Indianapolis, IN 46204
Fax: (317) 488-5169

Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 3.0	June 2004	All	Rewrite	TPL Department
Version 3.0	December 2004	All	Prepare for review	Leo Dabbs

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Section 1: Department Mail

Overview

Volume III of the Third Party Liability Operating Procedures describes the process for incoming mail, outgoing mail, and casualty case management. The Casualty Unit is responsible for distributing TPL Department incoming mail. Incoming mail often includes checks for casualty case settlement, HMS recovery, and sometimes child support. Procedures for processing these checks are included in this volume.

Mail Distribution

The Claims Support Unit opens all mail except mail addressed to specific individuals and envelopes that appear to contain a check.

The Claims Support Unit delivers incoming TPL Department mail daily to the Casualty Unit. A casualty analyst signs off on the *TPL Batch Sheet* provided by the mail clerk.

The Casualty analyst opens all envelopes, except those addressed to the director. If an envelope contains a check, refer to *Section 2: Cash Handling*.

The TPL casualty analyst distributes mail as follows:

- Casualty Unit mail
- Birth expenditure requests
- Health Unit mail

Casualty Unit Mail

Accident/Injury Questionnaire forms, letters from attorneys and insurance companies, caseworkers, and leads from various sources are handled by the Casualty Unit. Mail related to an existing case is distributed to the assigned analyst for handling. Mail unrelated to an existing case is given to the appropriate analyst for follow up.

Birth Expenditure Mail

Birth expenditure requests come from the Department of Family Services (DFS) for claim payment information for enrolled IHCP newborns and their mothers. Fathers are required to pay claims for the newborn instead of the IHCP. The *Claims Support Manual* provides information about sorting and batching birth expenditure requests. The mailroom staff delivers batches to the designated health analyst. Detailed procedures to process birth expenditure requests are in Volume II of the *TPL Operating Procedures Manual.*

Health Unit Mail

Health Unit mail consists of TPL questionnaires, updates, and terminations sorted and batched according to the procedures in the *Claims Support Manual*. Each batch cover sheet identifies the batch type, number of pieces, and Julian date. The Julian calendar is a consecutive 365-day calendar, with 366 days every fourth year, as opposed to a 12-month calendar with months of 30 or 31 days and 29

days in February every fourth year. For example, January 10 is Julian date 10. The analyst records the check-out date, their initials, completion date, and actual piece count on the cover sheet when the batch is completed.

Certified Mail Requirements

When opening new cases, requesting status, closing cases, and for settling cases Casualty analysts should send letters by certified mail to attorneys and insurance carriers. File the returned certified receipts in the case file to document receipt of the letters by the other party.

Use the following steps to send a letter by certified mail:

1. Place the green and white *Certified Mail Receipt (Form PS 3800)* at the top of the envelope to the right of the return address. Fold at the dotted line.
2. Tear off the bottom of *Form PS 3800* and staple it to the *file copy* of the letter.
3. Complete the front of *Form PS 3811* indicating to whom the letter is being mailed. Write the member's name on the form along with the analyst's initials to ensure receipt of the card by the correct analyst. After completing *Form PS 3811,* attach the card to the back of the envelope. Stamp the address for EDS on the back of *Form PS 3811*.
4. When returned, file the signed *Form PS 3811,* in the appropriate file.

Facsimile Operation Procedures

Use the following procedures to send a facsimile:

1. Go to facsimile machine located in the TPL area; dial 9 then the phone number. For example: 9 (xxx) xxx-xxx.
2. Place paper face up in the top tray.
3. Press the green send button located on the left side of the machine. On completion of the transmission a confirmation page prints indicating the transmittal was complete or incomplete.
4. Repeat steps 1 through 3 if transmittal was unsuccessful. If successful, place the confirmation page in the case file to document the transmittal.

Section 2: Cash Handling

Overview

The TPL Department receives settlement checks, HMS recovery checks, and sometimes child support (IV-D) checks. Settlement checks are to settle personal injury, workman's compensation, or medical malpractice cases when a third party carrier was liable and the IHCP paid related claims. HMS checks are for recoveries by HMS for claims paid by the IHCP when a third party carrier was liable for payment of the claims. Sometimes child support (IV-D) checks come to the TPL Department in error. This section provides procedures for handling the various checks received in the department.

Casualty Checks

Log checks received in the TPL Unit and deliver to the Finance Department within 24 hours of receipt. Return checks not deposited within 24 hours to the sender. Secure checks until delivered to Finance.

Use the following steps to send checks to the Finance Unit for deposit:

1. Checks generally have the member's name and number (RID) to identify the related case. If the analyst cannot determine the related case, contact the payer to obtain more information.
2. Review lien amount to ensure the check amount matches the settlement amount listed in the case file. Checks for compromise cases cannot be deposited until the compromise is approved by State attorney general. EDS cannot hold checks pending approval of a compromise case. Return checks received for unapproved compromise cases. Contact the attorney and send a letter, along with the check, back to the attorney.
3. Make a chronological note in the case file in Indiana*AIM* for each check received for an open casualty case. The chronological note must include the check date, check amount, check number, and the check writer's name, and the date sent to Finance or returned to the sender.
4. Print two copies of the chronological note. Paper clip one copy to the live check. Staple the second copy to any enclosures received with the check. Give one copy of the check, and any other information received with the check, to the casualty analyst assigned to the case.
5. Complete a *Daily Deposits Log* located at *L: Package Three/Casualty/Check Log/Daily Deposits.* The deposit log indicates the check date, check number, name of the check writer, and the TPL team member's initials. Print two copies of the deposit log.
6. Deliver the checks and the two deposit logs to the Finance Department before 2:00 p.m. the day of receipt. Hand the checks to a Finance team member; do not leave on the team member's desk. The finance clerk initials and dates both copies of the deposit log and keeps one copy for Finance files.
7. File the initialed copy of the *Daily Deposits Log* in the *Check Logs* binder.

Payment Discrepancy Reconciliation

Payments usually match the amount due to the IHCP. Use the following steps to reconcile the amount when a discrepancy occurs:

1. Pull the case file to determine the lien amount and to determine the check is for the agreed upon amount. The case file and Indiana*AIM Case Tracking Base* window both provide the current lien amount.
2. Contact the attorney, or insurance carrier, if the payment is less than the amount due to the IHCP to determine the difference and request additional payment.
3. If the payment exceeds the net amount due the IHCP process an *Expenditure Request.* The steps for preparing expenditure are located under Expenditures after Step 4. of this subsection. The Finance Unit prepares a check to reimburse the attorney or insurance carrier for the overpayment.
4. Close the case.

Expenditures

Submit an expenditure request to the Finance Unit to issue a refund check to an attorney, or insurance carrier, for the overpayment amount. Use the following steps to generate expenditure:

1. Inform the payee of the overpayment amount, and request the payee's tax ID number.
2. Log on to Indiana*AIM*.
3. Click **Finance** on the *Main Menu*.
4. Click **Expenditure**.
5. Click **New** on the *Expenditure Search* window.
6. Click **Other**.
7. Type in the payee information.
8. Click **Save**.
9. Tab to *Amount Paid* field and type the dollar amount of the refund check.
10. Tab to *Reason* field, click the down-arrow, and click **TPL Casual SYS**.
11. Tab to *State Letter No*. field and type the current date in MMDD format.
12. Tab to *IHCP ID* field and type the member's RID number.
13. Tab to *Program* field and click **IHCP**.
14. Click **Print**.
15. Click **Save**. Indiana*AIM* generates a five-digit expenditure number.
16. Note the five-digit number expenditure number for future reference.
17. Click **New**.
18. Type the attorney's tax ID number.
19. Tab to *FDOS/TDOS* field and type today's date in both fields.
20. Click **Save**.
21. Exit the windows.
22. The *Expenditure Request Form* is located under the *Finance* heading in Project Work Book (PWB).
23. Type in the five-digit expenditure number generated in Step 17 on the *Expenditure* line. Complete the form by typing the attorney's tax ID number, name, address, and the check amount.

24. Indicate the reason for the refund in the narrative section of the form. Include the member's name and number(RID) in the narrative and print two copies. Do not save this document. It is a template used for daily deposits.
25. Staple copies of the case tracking window, the check, and other supporting documents to the back of the expenditure form.
26. Give one copy to the supervisor to review and sign for authorization.
27. Place the copy in the case file.
28. Submit the expenditure to the Finance Unit. The following Tuesday, the Finance Unit will deliver the check.
29. Make a copy of the check for the case file and send the original to the attorney's office.
30. Notify the appropriate person in the Finance Unit to expect a check from the TPL Unit.
31. Open the *Case Tracking* window in Indiana*AIM*.
32. Click **Review/Closed** and click **Closed Partial Recovery**.
33. Click **Save**.
34. Click **Options**.
35. Click **Chrono Notes**.
36. Note that the refund check was sent to the attorney and the case closed.
37. Click **Save**.
38. Exit Indiana*AIM*.
39. Enter the case file on the month-end spreadsheet.

HMS Checks

List checks for HMS recoveries on the *Daily Deposits Log*, along with the casualty checks indicating **HMS** in the appropriate field. Take these checks to the Finance Department for deposit along with the casualty checks.

Child Support (IV_D) Checks

Occasionally the Child Support Division of the County Prosecutor's Office sends a child support check (IV-D) to the TPL Department. On receipt, place these checks in an inter-office envelope and forward to Financial Enhancement, Room E442 at the State office complex. Keep a copy of the check for reference in the *Child Support* folder in the TPL Department.

Settlement Check Endorsement

Sometimes a settlement check presented to the attorney is made payable to the IHCP and the member. A representative for the IHCP must endorse the check before the attorney can deposit the check and disburse settlement funds.

The TPL supervisor or department director can endorse settlement checks. The process is as follows:

1. Instruct the attorney to prepare a check for the net due the IHCP and present the settlement check for signature.
2. Notify the TPL supervisor that a signature is required.
3. Obtain the attorney's check for the net due the IHCP, request the TPL supervisor endorsement.
4. Process the attorney's check and take to the Finance Unit for deposit. Refer to *Live Check Procedures* for additional information.
5. Add chronological notes in Indiana*AIM* documenting receipt of the check.

Settlement Check Disposition

The following process tracks casualty checks delivered to the Finance Department. After a check is deposited and clears the bank, a Finance team member delivers a copy of the deposited checks, along with the *Daily Check Log* report, *ADJ-0001-D* to the TPL Unit. The report lists all the checks deposited and the cash control number (CCN) for each check. The cash control number is an internal tracking number assigned to each check. The casualty checks are always highlighted. Compare the *ADJ-0001-D* report to the *Daily Check Log* to ensure that checks delivered to Finance are deposited and clear the bank. Give a copy of the report to the appropriate casualty team member for posting.

Use the following steps to post a check:

1. Pull the case file for each payment received and open the corresponding case in Indiana*AIM*.
2. Change the status of the case to reflect receipt of the payment and change the review/closed date as necessary. The date indicates the case closed date or, if necessary, the next review date.
3. Click **Save.** Click **Options** on the tool bar and then click **Chrono Notes.** Type the appropriate note in the *Chrono Note* window.
4. A tortfeasor is required to post the check. Open the case and click **Options** on the toolbar and then click **Tortfeasor** from the drop-down menu. The *Tortfeasor/Case Xref* window displays. Type in the tortfeasor number listed. If the tortfeasor is unknown, create an entry by typing **332** in the *Tortfeasor Number* field.
5. At the toolbar, click **Options** and then **New**. The *Tortfeasor Info* window displays. Click **Select** to create a new entry. Click **Select** and click the appropriate tortfeasor.
6. Type the CCN listed on the *ADJ-0001-D* report and click **Save**.
7. If an incorrect CCN is typed and then saved, contact the appropriate team member in the Systems Department to correct the error.

After posting checks, print the *Casualty Collections Report* (*TPL-00027*) to validate the checks posted.

1. At the *TPL Menu* window click **TPL Reports**. The *TPL Reports Menu* window displays.
2. Click **Casualty Collections**. The *Casualty Collections* window displays the *TPL-0027-M* report format.
3. Type the date in YYYYMM format and click **Search**. The cumulative report for the current month displays.
4. Locate the checks posted, and write the member name and number (RID) on the report next to the appropriate CCN.
5. Verify the proper CCN was posted to the corresponding casualty case.
6. Prepare the lien release if necessary.
7. Request peer review to ensure accuracy.

The TPL attorney provides information about handling compromise checks. Post compromise checks like other casualty checks, but require additional documentation. Refer to the *Compromise Process* section.

When a check is received for reimbursement and there is not an open case, open a case to verify the IHCP expenses. If the check is for the correct amount, post the check, and then close the case. If the check exceeds the IHCP paid amount, refer to the *Generating Expenditures* section. It is not necessary to file a lien when settlement occurs prior to opening a case.

Section 3: Casualty Unit

Overview

When the IHCP pays medical expenses for an injured member or a member who has suffered an illness as a result of the negligence or act of another person, EDS, as fiscal agent for IHCP, is required to recover those expenses from any liable third party. Third party liability (TPL) refers to the legal obligation of individuals or entities that may have whole or partial legal or financial responsibility for medical expenses incurred by a member of State-funded medical assistance. The TPL Casualty Unit investigates and seeks reimbursement from individuals and entities that are legally responsible for injuries sustained by IHCP members.

An IHCP member often incurs injuries either due to an accident or medical malpractice. As a condition of eligibility for medical assistance, each member assigns his or her rights to third party payments to the IHCP and agrees to cooperate in obtaining payment from liable parties in such casualty cases. The IHCP pays the casualty-related claims, but begins an investigation of potential third parties who may be liable, whether by settlement or judgment, and who have resources to reimburse the IHCP.

Pursuant to *Indiana Code 12-15-8-1, et seq*., the IHCP is entitled to file and enforce a lien against any liable third party in the amount paid by the IHCP to the extent of the third party's liability for the medical expenses.

The TPL Casualty Unit investigates casualty cases, identifies casualty-related payments, and notifies potentially liable parties of the IHCP interests. The Casualty Unit also tracks casualty cases; arranges for repayment of casualty-related expenses, and communicates casualty-related information to members, attorneys, and insurers. The following sections provide the procedures relating to casualty cases.

Casualty Process Flowchart

Figures 5.1 and 5.2 provide a flowchart of the TPL Casualty Process.

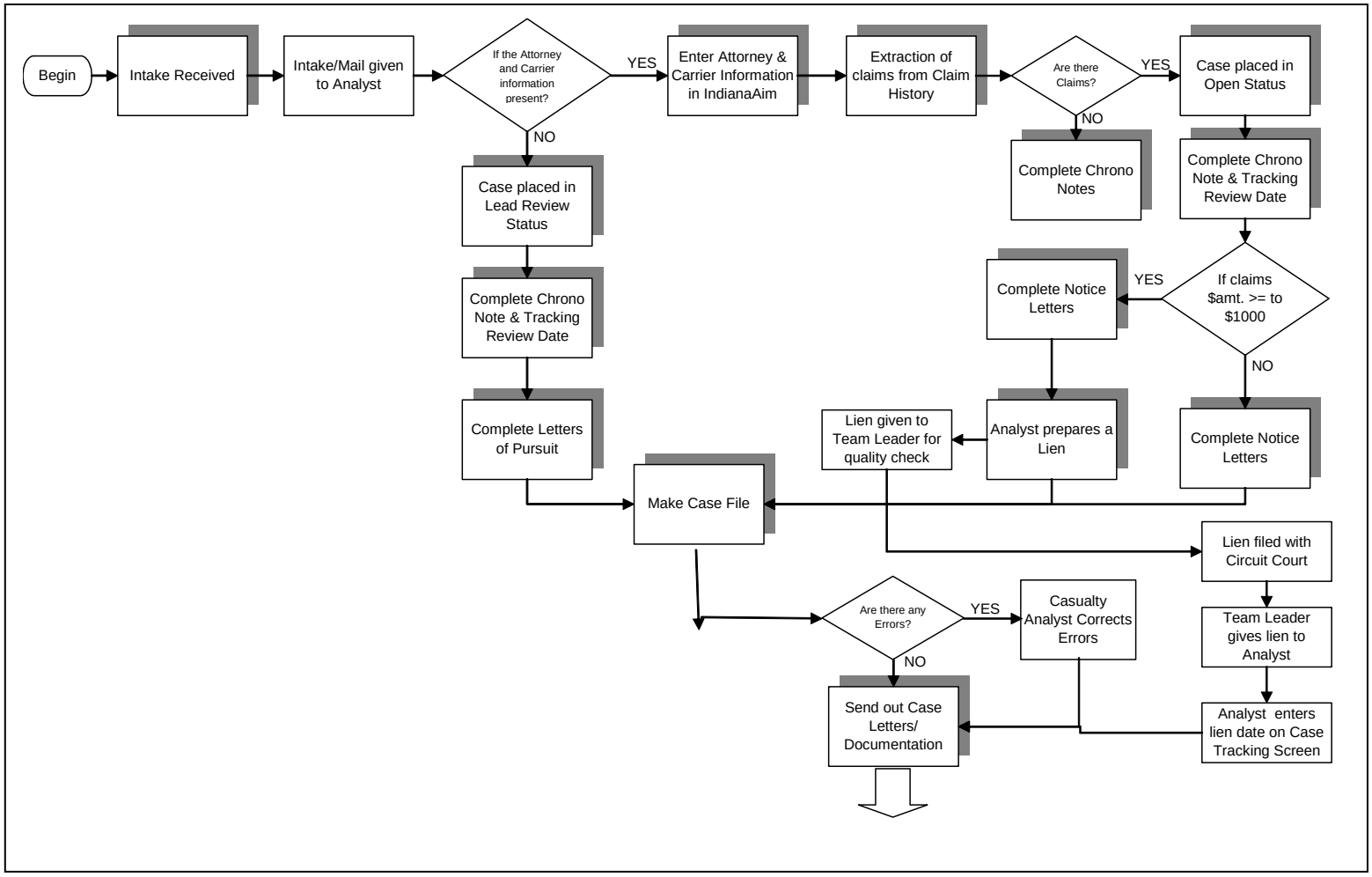


Figure 3.1 – TPL Casualty Procedures Process (part 1 of 2

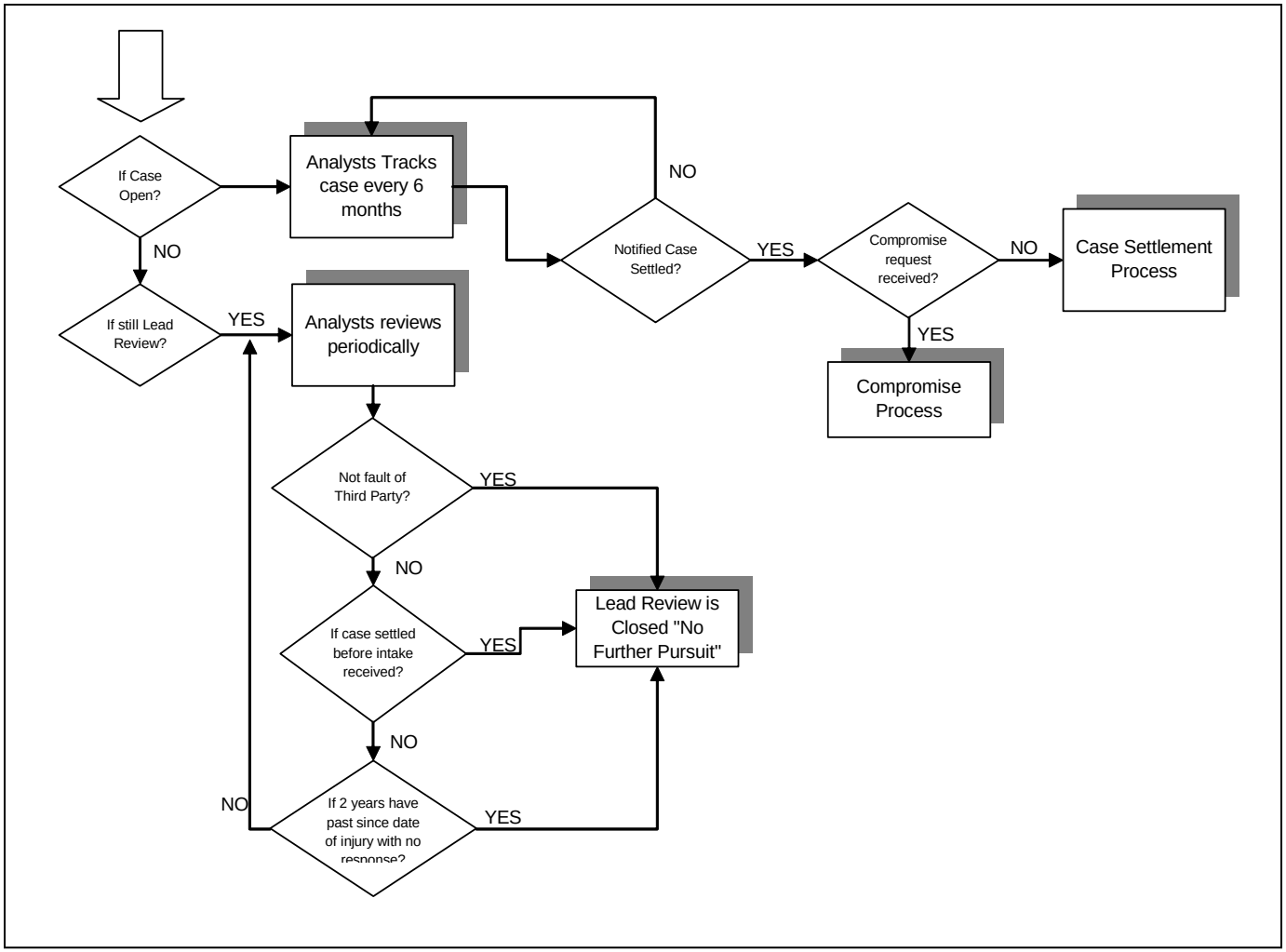


Figure 3.2 – TPL Casualty Procedures Process (part 2 of 2)

Accident Trauma Leads

Federal regulations require investigation of all IHCP paid claims with an accident indicator, or trauma diagnosis code for potential third party involvement. The *Accident/Trauma* report, *TPL-0009-M,* is generated monthly to identify potential recovery cases. Produced from the member claim history the report identifies paid claims with an accident indicator or when one of the first two diagnosis codes are within the range of diagnosis codes 800.0-999.9, which are defined as accident or trauma diagnosis codes. There are diagnosis codes within this range that are not generally accident related, such as insect stings and bites. These diagnosis codes are as follows and are exempt from this report:

- 900.0 – 919.5
- 950 – 958.8
- 990 – 995.89
- 996 – 998.9

Accident/trauma letters and questionnaires are systematically generated to each member based on claim history for research and follow-up. Indiana*AIM* automatically creates a casualty case and places the case in *Lead* status. The system also automatically populates the *Review/Closed Date* field of the *Case Tracking Base* window in Indiana*AIM* with a review date of one month from the date of the letter. Follow up letters are not generated until after 150 days to avoid sending repeated letters for the same incident. Identification of a potential recovery requires the casualty analyst to determine the availability of a third party resource.

Data Match Leads

There were originally three data matches used to generate leads:

- Malpractice
- State Police
- Worker's Compensation

The *Malpractice Data Match* was originally received by tape from the Indiana Department of Insurance (IDI). Technical difficulties often produced unusable or dated information. The EDS attorney works with an IDI attorney who sends, by e-mail, a monthly list of active medical malpractice cases from the IDI. After validation against the Indiana*AIM* eligibility file, analysts open a new casualty case for any name on the list matching a member in the eligibility file. Refer to procedures for opening a new case.

The *State Police Data Match* process was discontinued due to outdated and poor quality data.

The *Worker's Compensation Data Match* was discontinued by EDS and OMPP agreement in January of 2003.

Intakes

An *intake* was the initial notification of an incident involving an IHCP member and potential recovery from a liable third party from sources other than the system-generated letters. The *Intake* status was used when there was an intake coordinator in the Casualty Unit who opened all mail, set up new leads

as *Intakes*, and distributed to the Casualty analysts. The Casualty Unit no longer uses this status. All analysts now process their incoming mail, or new cases, and either *open* a case to follow up in the future, or change to *no further pursuit* if there is no TPL.

New Cases

New cases are received daily by mail, telephone, or fax from the following sources:

- Caseworker
- OMPP
- Member
- Provider
- Attorney
- Insurance agent or adjuster
- Tortfeasor (defendant)

Use the following steps to determine if a case already exists:

1. Log on to Indiana*AIM*
2. Click **Third Party Liability** on the *Main Menu – Production* window and the *TPL Menu* window displays.
3. Click **Casualty Case Tracking** and the *Casualty Case Search* window displays.

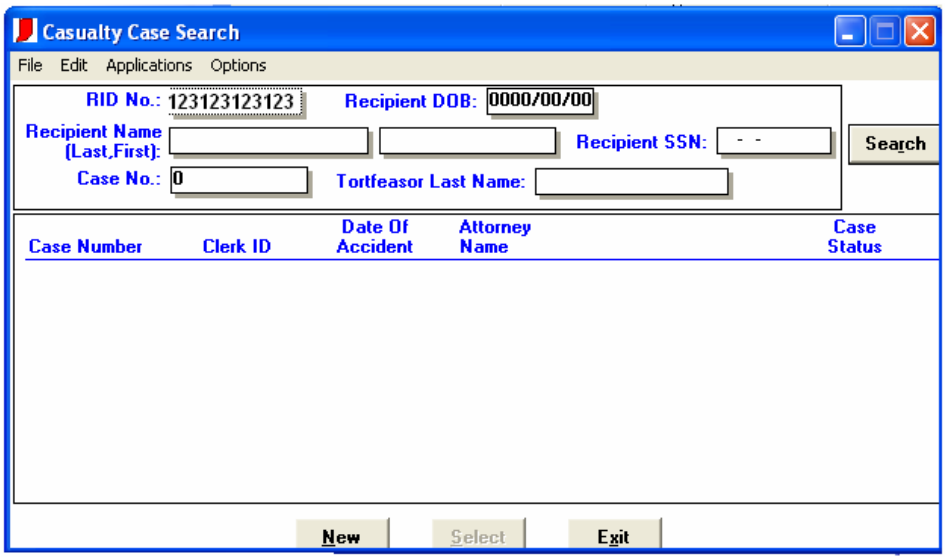


Figure 3.3 – Casualty Case Search Window

4. Type the RID number in the *RID No*. field and click **Search**. If information already exists in Indian*AIM* that matches the information, give to the appropriate analyst. When the information is

related to a different incident date, or when the message displays, `Record Not Found – Please Try Again`, click **OK** and process as a new intake. Process new intakes as follows:

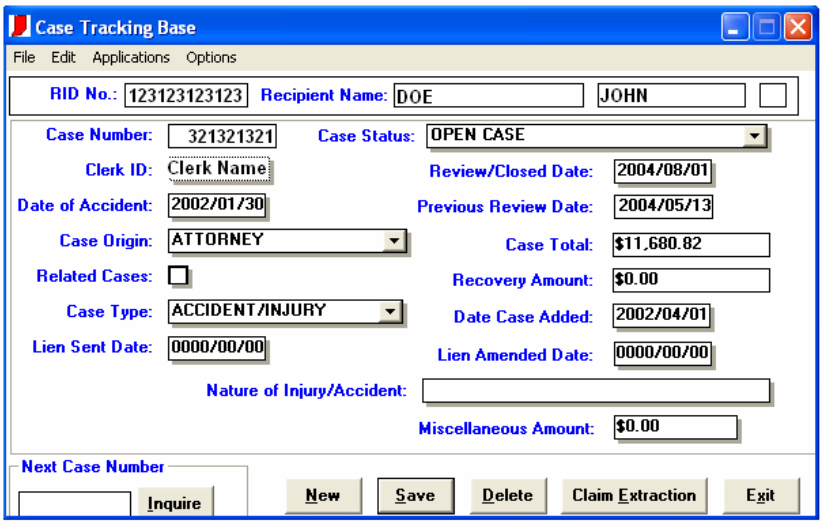


Figure 3.4 – Case Tracking Base Window

5. On the *Casualty Case Search* window, click **New** and the *Case Tracking Base* window displays.
6. Type the RID number in the *RID No.* field.
7. Type the analyst's initials in the *Clerk ID* field.
8. Type the date of the accident in the *Date of Accident* field.
9. Click the **Case Origin** drop-down menu and click the appropriate origin.
10. Change the auto-populated status to *Open* for future follow up.
11. If available, type a brief description of the member's injury in the *Nature of Injury/Accident* field. The *Review/Closed Date* field indicates the future review date. The field is systematically set at 0000/00/00. To systematically activate the next review, complete steps 13-18.
12. Type today's date in the *Review/Closed Date* field. Type the date in CCYYMMDD format. For example, type July 10, 1999, as 19990710.
13. Click **Save**. A message box displays indicating the save was successful.
14. Click **OK**.
15. Click **Review/Closed Date** to highlight the entire box.
16. Type the date two months from today's date in the *Review/Closed Date* field.
17. Click **Save**. The system populates today's date in the *Previous Review Date* field. The date two months from today's date is in the *Review/Closed Date* field. The case appears on the *TPL-00005 Report* the month the case is set for review reviewed. A dialog box prompts user to enter a chronological note.
18. Click **Yes** and the *Case Chronological Notes* window displays.

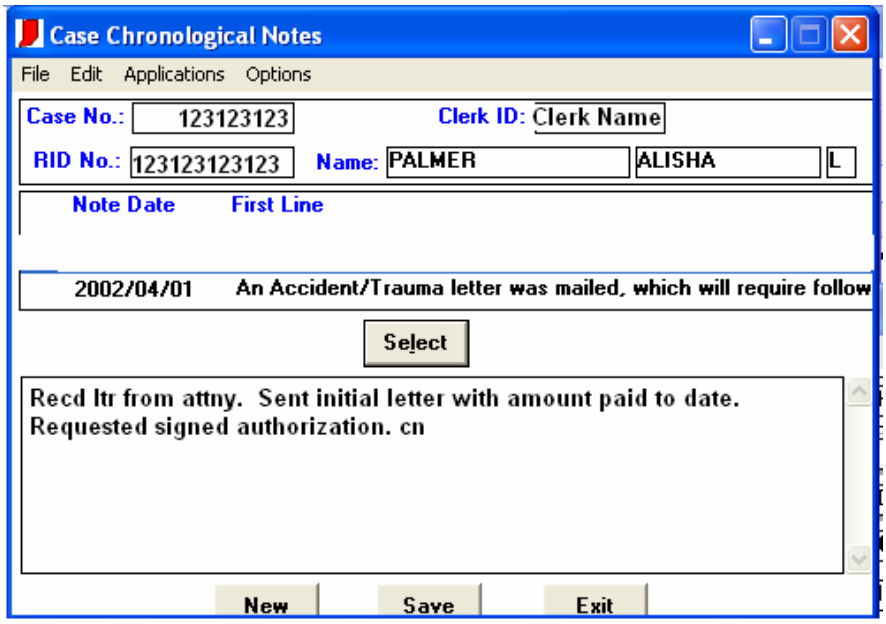


Figure 3.5 – Case Chronological Notes Window

19. Click **New** to display a new note page. The current date populates in the top data window. The lower box contains the words *New Chrono Note* highlighted in blue. Type in the new case information. Chronological notes are subject to subpoenae. It is important to provide accurate statements about the progress and management of the case. Make notes periodically until the case is closed and include information from phone calls, written correspondence, and faxes. The system automatically populates the current date for a new chronological note. Type initials after making a chrono note to identify who made the entry.
20. When the note is complete, click **Save** and then **OK**.
22. To print the note, click **File**, **Print,** and then **Print Window**. Place a copy of the note in the case file.
23. Click **Exit** until the *Casualty Case Search* window displays.

After making the initial determination about the action required for a new intake, add the daily intakes to the internal tracking log.

1. Open the Microsoft Excel application, click **File** and then **Open**. The directory path of the tracking log is *L:\Package Three\TPL\ Intakes\New Versions Intakes Year 2004.xls*. Type the following information on the spreadsheet:
   - Date
   - Analyst name
   - Member name
   - RID number
2. Type an X in the appropriate column to indicate the intake status and the date completed.

Case Maintenance

The casualty analyst makes the initial determination about pursuit of a case and performs ongoing case reviews until settlement. The procedures in this section address the different stages of a casualty case. The casualty analyst controls the review date by typing a new date in the *Review/Closed* field on the *Case Tracking Base* window. Case status determines the review schedule. Review the case immediately on receipt of a written or verbal request. Review cases in *Lead* status every three months and review open cases every six months.

After review change status to one of the following:

- No further pursuit (NFP)
- Open case

No Further Pursuit

Change *intake* or *lead* status to *no further pursuit* (*NFP*) when research determines the following:

- Liable third party cannot be identified
- Member does not pursue legal action
- Two or more years have elapsed since the accident and no lawsuit filed; therefore, the statute of limitations has expired. A minor can file a lawsuit up to two years following their 18th birthday
- One-year filing limit has expired and there are no paid claims

Lead Review

A lead received without attorney or carrier information, requires a pursuit letter to the member requesting the attorney, insurance, and tortfeasor information.

Change the status to *Open* so it will appear on the monthly *Case Review* report and revise the *Review/Closed* date for follow up using the steps below:

1. Log on to Indiana*AIM.*
2. Click **Third Party Liability** on the *Main Menu – Production* and the *TPL Menu* window displays.
3. Click **Case Tracking** and the **Case Tracking Menu** displays.
4. Click **Casualty Case** and the *Casualty Case Search* window displays.
5. Type the RID number in the *RID No.* field.
6. Click **Search**. The case information displays. If more than one case displays, highlight the appropriate case.
7. Click **Select**. The *Case Tracking Base* window displays
8. In the *Case Status* field click **Open** from the drop-down box.
9. Type the Indiana*AIM* logon ID in the *Clerk ID:* field.
10. Double-click *Review/Closed Date* field to highlight the entire box.
11. Type the current date in the window in CCYYMMDD format. For example, type July 10, 1999, as 19990710. This automatically populates the date in the *Previous Review Date* field when saved. The *Case Origin, Case Type, Date of Accident,* and *Nature of Injury/Accident* fields may contain case information. If not, type in any information available at this time.

12. Click **Save** and a message box displays, `Save Successful`.
13. Click **Ok**.
14. Double-click *Review/Closed Date* field to highlight the entire box. Type the future review date.
15. Click **Save**. The system populates today's date in the *Previous Review Date* field. The future review date appears in the *Review/Closed Date* field. The case will appear on the *Case Review Report* for the month the case is scheduled for review. The message box prompts the user to enter a *Chronological Note*.
16. Click **Yes**.
17. Click **New** on the *Case Chrono* window. The system populates the current date in the top data window. The lower box contains the words *New Chrono Note* highlighted in blue. Type in important information about the case status. Chrono notes are subject to audits and subpoena. It is important to provide accurate statements about the case management. Make chrono notes on receipt of new information or requests about the case. Type initials at the end of the note to identify who made the note.
18. Click **Save.** If attorney, insurance, or tortfeasor information is not available, set the case review for three months and proceed to *Pursuit Letter to Member* procedures. If the attorney and insurance information is available proceed to *Entering Carrier/Attorney/Tortfeasor Information* procedures. Always open a case when attorney information is available.

Member Pursuit Letter

Send a pursuit letter to the IHCP member when there is no TPL or attorney information available about a possible casualty case. The letter explains the two-year statute of limitations, asks for attorney and insurance carrier information, and provides a toll-free number to call if there are questions.

1. Open Microsoft Word.
2. Click **File**.
3. Click **Open**. The directory path for the letter is *L:\Package Three\Casualty\Casualty Letters 2004\Member Pursuit Notice with Statute of Limitations.doc*.
4. Type today's date in the *Date* field.
5. Type the member name and address in the appropriate fields.
6. Type the member's name, RID number, and the date of the accident in the *RE* field.
7. Type the name of the person to whom the letter is addressed in the *Dear* field. If the member is a child or minor, address the letter to the *Parent of …* or *Guardian of….*
8. Type the analyst's name, title, and toll-free number at the end of the letter.
9. Click the **Spelling and Grammar** icon on the tool bar to spell check the document.
10. Click **File**.
11. Click **Print**.
12. Click **Ok**.
13. Retrieve a copy of letter from the printer, sign the letter, and make two copies. Mail one copy to the member and place the other copy in the case file.

Open Status

When the intake or lead meets the criteria to open a case change the status to *Open*.

Send *Notice Letters* to the appropriate parties to inform them of the total IHCP expenses; include the member, the member's attorney, the tortfeasor, the tortfeasor's attorney, and the insurance agent handling the claim. Send *Notice Letters* by fax or certified mail.

Set the review date for no more than six months. Review cases more frequently if settlement is pending or if the injuries are severe and it appears that the IHCP expenses may increase rapidly.

Insurance Carrier, Attorney, and Tortfeasor ID Numbers

When opening a case the attorney and the other insurance carrier, for the member or for the tortfeasor, are given a system-generated ID number. Use the following steps to generate a system-assigned ID number for the attorney, insurance agent, and tortfeasor:

1. Log onto Indiana*AIM*.
2. Click **Third Party Liability** on the *Main Menu – Production* and the *TPL Menu* displays.
3. Click **Case Tracking** and the *Case Tracking Menu* displays.
4. Click **Attorney** and the *Attorney Search Screen* displays.
5. Type the attorney's name in the *Attorney Name* field.
6. Click **Search**.
7. If no match continue with Step 8. If the attorney is in the system a four-digit number displays. Proceed to Step 11.
8. Click **New**.
9. Type in the attorney's name and address in the *Case Tracking Attorney Screen.*
10. Click **Save**. System-assigned four-digit attorney number displays. Type this number in the case windows to add attorney information to the case file.
11. Note the attorney number for future reference.
12. Click **Exit** until the *Case Tracking Menu* appears.
13. If the tortfeasor information is available, continue with the following steps. If there is no tortfeasor, go Step 22.
14. Click **Tortfeasor** on *Case Tracking Menu* and the *Tortfeasor Tracking* window displays.
15. Type in the tortfeasor name and address and click **Search**.
16. If there is no match, continue with Step 17. If the tortfeasor is already in the system, go to Step 21.
17. Click **New** and the *Tortfeasor Base* window displays.
18. Type in the tortfeasor name and address and click **Save**. Indiana*AIM* assigns and displays a tortfeasor number.
19. Note the tortfeasor number for future reference.
20. Click **Exit** until the *Case Tracking* menu displays.
21. Click **Insurance Agent** and the *Insurance Agent Search* window displays.
22. Type the insurance agent's last name, first name, and click **Search**.

23. If there is no match, continue with Step 27. If the insurance agent is in the system, go to Step 26.
24. Click **New** and *Insurance Agent Base* window displays.
25. Type the company name, insurance name, and address on the *Insurance Agent Base* window.
26. Click **Save**. Indiana*AIM* assigns and displays an insurance agent number. Type this number in the case windows to add this information to the case file.
27. Note the insurance agent number for future reference.
28. Click **Exit** until the *Case Tracking Menu* window appears.

After obtaining the attorney, insurance, and tortfeasor ID numbers, add the information to the case file in Indiana*AIM* and change the case status to *Open.*

29. On the TPL Menu, click **Case Tracking** to display the *Case Tracking Menu.*
30. Click **Casualty Case** and the *Casualty Case Search* window displays.
31. Type the RID number in the *RID No* field.
32. Click **Search**.
33. Click **Select**.
34. At the *Case Status:* field, click the drop-down arrow to display the case status options.
35. Click **Open Case**.
36. Click **Save**. Message box prompts user to add a chronological note. Click **Yes** or **No** as appropriate.
37. Click **Options**.
38. Click **Recip Info**.
39. Type the attorney number in the *Attorney Number* field.
40. If the member's insurance information is available, type the insurance number in the *Ins. Agent Number* field.
41. Click **Save**. The system automatically populates the attorney information.
42. Click **Exit**.
43. Click **Options**.
44. Click **Tortfeasor Info**.
45. Click **New**.
46. Type the tortfeasor number in the *Tortfeasor Number* field.
47. Click **Save**.
48. If the tortfeasor's insurance information is available, type the number in the *Ins. Agent Number* field.
49. Click **Save**. The system automatically populates the tortfeasor's insurance information.

Review Paid Claims Data

Review paid claims data to determine the claims related to the incident based on diagnosis, dates of service, and services provided. Request paid claims data through Indiana*AIM* on a *Medicaid Claims Expenditures* report.

Paid claims data is available as follows:

- Indiana*AIM* maintains seven years of paid claims data
- Data for claims paid before February 1995 is on microfiche
- Only fee-for-service claim data is provided to the attorney or insurance carrier. If the member was enrolled in a managed care organization (MCO) at any time during the *from* and *to* dates of service relating to the accident or injury, the attorney or insurance carrier must request information from the MCO.

Add Claims to an Open Case

Add related claims to the open case to create the claims summary report and provide a total for claims paid. This amount can increase or decrease at each review based on continuing treatment or information that alters the circumstances of the case.

Use the following steps to extract claims data from Indiana*AIM:*

1. Click **Claim Extraction** on the *Case Tracking Base* window.
2. Type the date of the accident in ccyymmdd format in the *FDOS* (from date of service) field.
3. Type the current date in the *TDOS* (to date of service) field.
4. Click **Fee for Service** to extract only fee-for-service claims. Refer inquiries for members enrolled in an MCO to the MCO.
5. Click **Search**. If there are no claims, make a chrono note that there were no claims for the date of accident.

If there are fee-for-service claims, complete the following steps to extract claims to build the casualty case. Sort and customize the claims data to place the claims data in chronological order, exclude adjusted claims, and include the claims paid amount, provider name, and diagnosis code. Use the following steps to sort and customize:

1. Click **Options**.
2. Click **Sort**.
3. Under *Sort#1* click **FDOS**.
4. Under *Sort#2* click **TDOS**.
5. Under *Sort#3* click **Claim Type**.
6. Click **OK**.
7. Click **Options**.
8. Click **Customize**.
9. Click **Claim Header Info**, **Diagnosis Code**, **Exclude Adjusted Claims**, and **All Name Info**.
10. Click **OK**.

Extract the claims based on the claims identified on the *Medicaid Birth Expenditure* report related to the accident or injury.

Use the following steps to view additional information about the diagnosis:

1. Double-click the first claim in the data window.
2. Click **Claim**.

3. Click **Diagnosis**.
4. Double-click the diagnosis code. The *Diagnosis Maintenance* window displays with the description of the diagnosis code.
5. If the diagnosis is related to the casualty case click **Add to Case**.

After extracting all claims, click **Exit** until the *Case Tracking Base* window displays. The total claims paid amount related to the accident or injury populates in the *Case Total* field.

Complete Notice Letter

A *Notice* letter informs the member's attorney, the member's insurance carrier, and the defendant's insurance carrier of the total amount paid by the IHCP. Send notice letters by facsimile or certified mail. File the facsimile confirmation or a copy of the return receipt for reference.

The letter provides the specific *Indiana Codes* and *Code of Federal Regulations*, lien amount, and a phone number to call with questions. It states the Family and Social Services Administration (FSSA) has the ability to pursue the liable third party to the full extent of the law. Procedures for completing the *Notice* letter are as follows:

1. Open Microsoft Word.
2. Click **File**.
3. Click **Open**. Open the file using the directory path, *L:\Package Three\Casualty/Casualty Letters 2004\Initial Attny Notice* or *Initial Ins Co Notice.doc*.
4. Type today's date in the *Date* field.
5. Type the attorney's name and address.
6. Type the member's name and date of accident in the *RE* field.
7. Type the name of the person to whom the letter is being addressed in the *Dear* field.
8. Type the lien amount in the *Lien Amt*. field. If the lien amount is $1,000 or greater, the sentence, "A notice of lien is forthcoming…" must be in the sentence directly following the lien amount. Delete this sentence for lien amounts less than $1,000.
9. Determine member enrollment in the Hoosier Healthwise RBMC Program and insert the appropriate information into the letter. Refer to the procedure for *Determining Eligibility in Hoosier Healthwise RBMC Program* under Heading *Other Situations* in this section for more information.
10. Type the name, title, and toll-free number at the end of the letter.
11. Click the **Spelling and Grammar** icon on the toolbar to check spelling.
12. Click **File**.
13. Click **Print**.
14. Click **Ok**.
15. Sign the letter and mail or fax as appropriate. If mailing the letter, refer to procedures for *Mailing a Certified Letter*.
16. Make a copy of the letter and the claims extraction report for the case file.

Medical Lien

If the case has a paid claim amount of $1,000 or greater, prepare a *Notice of Lien*. Filing the *Notice of Lien* protects the interest of the IHCP. Prepare an *Amended Notice of Lien* when the existing lien increases or decreases. Prepare a *Release of Lien* on receipt of the lien payment and the close the case. Send copies to all involved parties after filing with the court clerk.

Prepare Lien

1. Open Microsoft Word.
2. Click **File**.
3. Click **Open**. Open the file using the directory path *L:\Package Three\Casualty Letters 2004\ Notice of Lien.doc*.
4. Type the member's name and address.
5. Type the dollar amount of the lien.
6. Type today's date.
7. Type the tortfeasor's name.
8. Type the insurer's name.
9. Type the name, area code, and telephone number at bottom of letter.
10. Click **File**.
11. Click **Print**.
12. Click **OK**. Make two copies on State letterhead for filing. Refer to the *Filing Liens* section to complete this procedure.

Amend Lien

File an *Amended Lien,* if the paid claim amount increases or decreases. After filing amends with the court clerk, send copies to all interested parties. Use the following steps to amend a lien:

1. Open Microsoft Word.
2. Click **File**.
3. Click **Open**. Open the file from the directory path *L:\Package Three\Casualty Letters 2004\Amended Lien.doc*.
4. Type the cause number from lien notice. The cause number is on the original lien notice in the case file.
5. Type the name and address of member in the appropriate field.
6. Type the revised dollar amount.
7. Type the tortfeasor name.
8. Type the insurer's name.
9. Type the original filing date.
10. Type name, title, and telephone number at the bottom of letter.
11. Click **File**.

12. Click **Print**.
13. Click **OK**.
14. Make two copies on State letterhead for filing. Refer to the *Filing Liens* section to complete this procedure.

Release Lien

File a lien release on receipt of payment before closing the case. Use the following steps to prepare the lien release:

1. Open Microsoft Word.
2. Click **File**.
3. Click **Open**. Open the file from the directory path *L:\Package Three\Casualty Letters 2004\Release of Lien.doc.*
4. Type the cause number from lien notice. The cause number is on the original lien notice in the case file.
5. Type the name and address of member in the appropriate field.
6. Type the revised dollar amount.
7. Type the tortfeasor name.
8. Type the insurer's name.
9. Type the original filing date.
10. Type name, title, and telephone number at bottom of letter.
11. Click **File**.
12. Click **Print**.
13. Click **OK**.
14. Make two copies on State letterhead for filing. Refer to the *Filing Liens* section to complete this procedure.

Establish Future Review Dates

After opening a case and sending the initial notice letter to the attorney or insurance carrier, and if applicable, filing the lien, the analyst completes the following steps to for future case review:

1. Double-click **Review/Closed Date** to highlight the entire box.
2. Type today's date in CCYYMMDD format. For example, type July 10, 1999, as 19990710.
3. Click **Save**. The message box displays, `Save Successful`.
4. Click **OK**. A message box to prompts entry of a chronological note.
5. Click **No**.
6. Double-click **Review/Closed Date** to highlight the entire box.
7. Type the future review date, usually six months for an open case. The review date can be more frequent than six months, depending on the circumstances.

8. Click **Save**. The system automatically populates today's date in the *Previous Review Date* field. The future review date is in the *Review/Closed Date* field. The case will appear on the *TPL-0005 Report* the month the case is set for review. A dialog box entry of a chronological note.
9. Click **Yes**.
10. Click **New** on the *Case Chrono* window. The current date populates in the top data window. The lower box contains *New Chrono Note* highlighted in blue. The system automatically enters the current date for the new note. Make notes about the status of a case periodically from opening a case until closing. Notes are subject to subpoena. Provide accurate statements about the process and management of the case. Type initials at the end of each note to identify who made the entry.
11. Click **Save** when finished with the chronological note.

Prepare Case File

After completing the notes and updating the case review date in Indiana*AIM,* assemble the case file as follows:

1. Use a 14 x 9 manila file folder with two-hole prongs at the top of each side.
2. Place all correspondence from the attorney on the left side of the folder, most recent on top.
3. Place all other documents on the right side, most recent on top.
4. Staple liens, amends, or releases on the bottom left side of the folder, most recent on top.
5. Label the folder tab with the last name first, first name, and member identification number (RID).

File Lien

File lien notices weekly with the court clerk at the City-County Building. Leave the initial notices with the court clerk until the following week to allow processing time. The court clerk stamps a cause number on each new lien. The following week the clerk returns one copy for the casualty files. Amended and released liens are stamped at the time of filing and the extra copy is returned immediately. Type the information from the filed liens, amends, and releases in the *Lien Activity* spreadsheet using the following steps:

1. Open Microsoft Excel.
2. Click **File**.
3. Click **Open**. Open file from directory: path *L:\Package Three\ Casualty\Liens\Lien Activity 2004.xls.* Each month has a separate worksheet tab.
4. Click the appropriate month's tab. Liens, amends, or releases have a separate section on the spreadsheet.
5. Add the following information in the appropriate spaces:
   - Date
   - Member name
   - Cause number
   - Lien amount
6. Click **File**.
7. Click **Save**.
8. Click **Exit** to close Microsoft Excel.

9. Distributes the new lien notices to the assigned casualty analyst.
10. Send copies of the lien to all involved parties. This includes the member's attorney, the member, the defendant's attorney, and the defendant's insurance carrier.
11. Place the original stamped document in the case file.

Case Settlement

After settling a casualty case, the attorney or defendant's insurance company notifies the TPL Unit. When an attorney is involved, the HCP must reimburse the attorney's fees and pro rate share of expenses pursuant to *Indiana Code (IC) 12-15-8-7* through *12-15-8-9*. If the member worked directly with an insurance carrier the carrier notifies TPL of the settlement and inquires about the final payment. There are no fees from the settlement when the member works directly with the insurance carrier.

When notified by the attorney or insurance carrier of a case settlement, follow the steps below:

Settlement Notice

1. Calculate the net amount due:
   - When the member settles with an insurance carrier there are no fees deducted. The full amount of related paid claims is due the IHCP.
   - When the member works with an attorney, calculate attorney fees at 7.5 or 10 percent along with a pro rata share of expenses.
2. Report the amount due the IHCP to the insurance carrier or the attorney. Provide an opportunity to dispute or confirm the amount prior to making payment.

Disputes generally concern differences in the calculation method or claims that appear unrelated to the case. Review calculations to resolve variances. Review disputed claims data and adjust the recovery amount if applicable.

Determine Settlement Amount

Settlement of a case usually occurs through mediation, court hearing, or agreement with the defendant's carrier. An attorney may or may not be involved with a casualty case. The IHCP member, or responsible party, can work directly with an insurance carrier. In those cases the carrier sends a check directly to the IHCP. The majority of TPL casualty cases involve an attorney.

At settlement, deduct attorney fees from the IHCP lien amount as follows:

- 7.5 percent fee when suit is not filed
- 10 percent fee when a suit is filed

The attorney must provide the total case settlement amount and an itemization of attorney expenses to calculate the settlement amount. If the necessary documentation is not available, the attorney can present alternate documentation or can request a variance. These situations and requests are approved on a case-by-case basis. When an attorney is unresponsive to calls and letters, allow 25 percent for attorney fees and no pro rata share for reimbursement.

Non-compromise Worksheet

The IHCP requires percentages be carried out to the fourth decimal point for compromise and non-compromise case settlements.

To calculate the net amount due to the IHCP, an Excel worksheet is available for compromise and non-compromise cases. Use the following steps to make the appropriate calculations.

1. Open Microsoft **Excel**.
2. Click **File**.
3. Click **Open**. The worksheet is located at directory path *L:\PackageThree\CASUALTY\Letters\Non Compromise Settlement Worksheet.xls.*
4. Type IHCP lien amount, settlement amount, and total attorney's expenses into the *Non Compromise Settlement Worksheet*. The *Non Compromise Settlement* worksheet calculates the settlement based on a 7.5 or 10 percent reduction plus a reduction for a pro rata share of attorney expenses. The *Non Compromise Settlement* worksheet follows the calculation procedures for a statutorily reduced lien and returns the calculated values for the attorney fee, pro rata share allowed, and net due to the IHCP.

Close Case

Close cases after posting payments in Indiana*AIM*. Use one of the following explanations:

- Closed – full amount minus attorney fee; lien amount minus 7.5 or 10 percent attorney fees
- Closed – full amount; closed full lien amount
- Closed – partial recovery minus attorney fees
- Closed – partial recovery; no fees
- Closed – no recovery

Compromise Process

The compromise process begins after the settlement of a casualty when the member has retained an attorney. The IHCP is required to reimburse a portion of the member's attorney fees and a pro rata share of expenses pursuant to *Indiana Code sections 12-15-8-7* through *12-15-8-8*. The IHCP is also required to proportionally reduce the IHCP lien when the recovered amount is less than the full value of the case, pursuant to *Indiana Code 34-51-2-19*. The following cases are the basis for lien reduction in Indiana:

- *Pedraza v. Grande, 712 N.E.2d 1007* (Ind.App. 1999)
- *In re Wade 711 N.E.2d 851* (Ind.App. 1999).

The compromise process is the responsibility of the TPL attorney, who works with the plaintiff's attorney through the initial stages of the compromise, prepares the recommendation, and tracks progress of the compromise through presentation to the IHCP. The following sections provide a flowchart and the procedures followed during the process.

The *Work flow Procedures* section provides information about identifying, managing, and settling compromise cases in Indiana*AIM*. The procedures also address corresponding with attorneys, tracking compromises, and preparing and submitting narrative recommendations to the IHCP.

Compromise Flowchart

Figure 3.6 provides a flowchart of the compromise process.

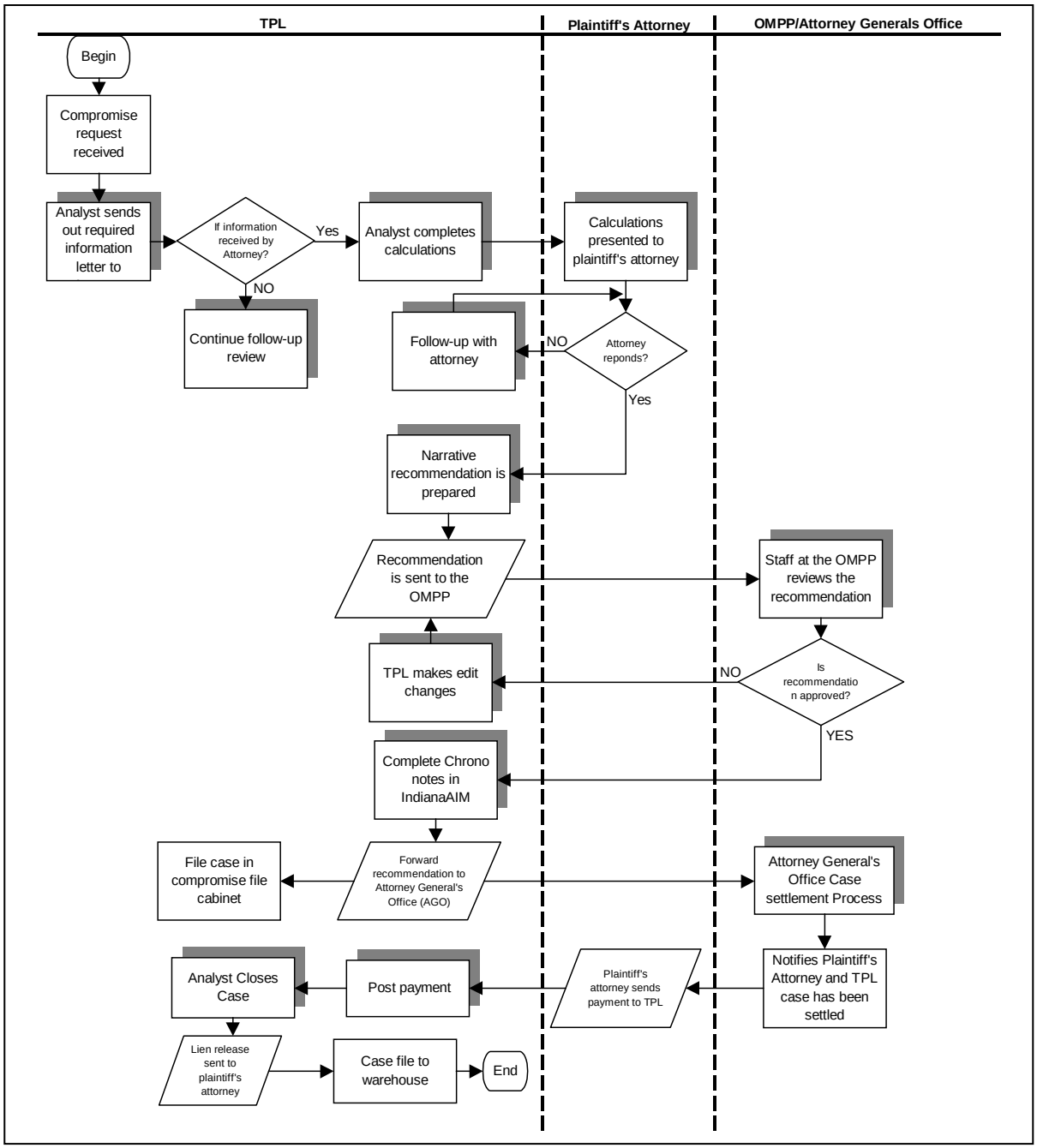


Figure 3.6 – Compromise Process

Transfer Compromise Case to TPL Attorney

The member's attorney generally sends notice when a case settles. The member's attorney may request reduction of the IHCP lien by an amount greater than the amounts allowed under *Indiana Code* sections *12-15-8-7* through *12-15-8-8*. The compromise process is as follows:

1. Receive compromise request from a member's attorney by phone or written correspondence.
2. Send *Compromise Document Request* letter to the member's attorney and places a copy in the case file.
3. Change case status in Indiana*AIM* to *In Compromise*. Add a chronological note to indicate the request for compromise and transfer file to the TPL attorney.
4. Change the clerk ID in Indiana*AIM* to TPL attorney ID.

Verify Compromise Case

The TPL attorney confirms the need for a compromise, and to save time and the detailed documentation required for a compromise, gives the member's attorney the option to forego a compromise. The compromise process is the responsibility of the TPL attorney. If the member's attorney decides not to go through the compromise process, the TPL attorney returns the case to the casualty analyst for settlement. The TPL attorney uses the following steps for compromise requests:

1. Contact the member's attorney on receipt of the request by phone or in writing to advise the time required for a compromise compared to statutory reduction. If the member's attorney decides to accept a statutory reduction rather than pursue a compromise, continue to step 2. If the attorney decides to continue to pursue a compromise, skip to step 3.
2. Return the case to the casualty analyst for a statutory reduction settlement when the member's attorney decides not to pursue a compromise. Make the following changes in Indiana*AIM*:
   - Change case status to *Open Case.*
   - Change clerk ID to the original casualty analyst.
   - Add chronological note indicating the attorney has elected statutory reduction and the file was returned to casualty analyst.
3. Update the *Compromise Log* when the requested documentation is received, add the new compromise case information, and note the status of the new case is *Docs Ltr Sent* the date of letter.
4. Proceed to the *Compromise Calculation* process on receipt of the requested documentation.

Compromise Calculation Process

After sending the document request letter to the member's attorney, the TPL attorney review the case monthly for a response. Information required from the member's attorney includes the following:

- Value of case
- Settlement amount
- Expenses
- Medical information
- Insurance and med pay information

The calculation process includes the following steps:

1. Review all of the documents received from member's counsel in response to the *Document Request* letter for thoroughness.
2. Advise the member's attorney by phone or in writing about any missing information.
3. Send a courtesy letter to the member's attorney stating the calculation totals in the recommendation presented to the attorney general and governor.
4. Process first the settlement amount, case value, and attorney's expenses.
5. Add the member's name, member ID (RID), IHCP lien amount, case value, settlement amount, attorney's expenses, and percent at fault assessed to the member, if any, to the *Compromise Settlement Worksheet* at directory path *L:Package Three\Casualty\Compromise\Templates/Settlement Worksheet.xls*. The *Compromise Settlement Worksheet* calculates the reductions when the member has not received the full value of their claim.
6. Place a copy of the *Compromise Settlement Worksheet* in the case file.
7. Prepare the *Compromise Calculation* letter, using the figures from the *Compromise Settlement Worksheet*, and send to the member's attorney.
8. Place a printed copy of the *Compromise Calculation* letter in the case file.
9. Skip to step 12, if the member's attorney responds and confirms the calculations. Continue with step 10 if the member's attorney disagrees with the calculations.
10. Consult with the member's attorney to verify the figures and negotiate any further calculations.
11. Add the calculations agreed on to the *Compromise Settlement Worksheet* and send an amended *Compromise Calculation* letter to the member's attorney.
12. Proceed with the narrative recommendation after confirming the calculations with member's attorney.

Narrative Recommendation Process

A narrative recommendation must be prepared for a lien compromise and sent to the OMPP for approval. The narrative recommendation summarizes the facts of the case, the member's medical treatment related to the case, facts of the settlement, the calculations, and the recommended compromise figure. The OMPP forwards the narrative recommendation to the office of the attorney general (OAG) for review. The OAG reviews the recommendation, and on approval, forwards it to the governor's office for secondary approval. The governor's office returns the approved compromise to the OAG who notifies the member's attorney of approval of the lien compromise. The OAG informs the member's attorney of the final net lien amount due to the IHCP and reviews remittance procedures.

The following procedures are for preparing the narrative recommendation:

1. Prepare a narrative recommendation on receipt of confirmation in response to the *Compromise Calculation* letter and confirmation of the calculations.
2. Open a new *Narrative Recommendation* in Microsoft Word, using the *Narrative Recommendation* template located at directory path *L:Package Three\Casualty\Compromise\templates non-merge\Narrative Recommendation.doc*
3. Review the documentation sent by the member's attorney, make a legal analysis of the facts surrounding the incident, and prepare a statement of the facts.
4. Review the documentation presented by the member's attorney for all legally relevant medical treatment received by the member. Document the nature of the claimed injuries or illnesses in the narrative recommendation.

5. Prepare a statement of facts leading to the settlement of the member's claim and naming all responsible third parties involved in the settlement.
6. Copy the compromise calculation from the *Compromise Calculation* letter previously prepared.
7. Complete the *Narrative Recommendation* and place a copy in the case file.
8. Submit the *Narrative Recommendation* to the department director by e-mail.
9. Assign a tracking number to the letter and type on the *Narrative Recommendation*. Add the member's name and RID number to the *Compromise Log*, along with the date submitted to the IHCP.
10. Work with the IHCP to modify the narrative if modifications are required prior to presentation to the OAG and governor. The OAG notifies the TPL attorney on approval of the compromise.
11. Add the date of the OAG notice letter to the *Compromise Log* stating approval by OAG. Refer to the *Compromise Payments* section for posting checks received for a compromise case.
12. Copy the recovery check, after posting in Indiana*AIM*, and send to the deputy attorney general. The check copy verifies receipt of payment and the OAG closes their file.
13. Add chronological note in Indiana*AIM* noting receipt and posting of check send a copy to the OAG.
14. Move the case information to the *Completed Cases* worksheet on the *Compromise Log*.
15. Prepare, and file, a lien release with the court clerk.
16. Place a copy of the filed lien release in the case file.
17. Mail the original lien release to the plaintiff's attorney.
18. Add the settlement figures and member information to the *Data Analysis Worksheet* log.
19. Log the case on the *Storage Sheet* and *Settled Case Log*.
20. Place the case file in the appropriate box for off-site storage.

Casualty Recovery and Managed Care

The Casualty Unit does not recover expenses paid by an MCO that is part of the Risk-Based Managed Care Program. Use the following steps to determine member enrollment in the RBMC program:

1. Log on to Indiana*AIM*.
2. Click **Recipient** on *Main Menu*.
3. Type the RID number in *RID No*. field.
4. Click **Search**.
5. Click **Select**.
6. Click **Options**.
7. Click **PMP assignment**. If the date of accident or injury falls between the *Start Date* and the *End Date* field and there is an MCO number in the *MCO* field, the analyst notes the *Start Date*, *End Date*, and MCO number for future reference. Continue with step 8 to obtain contact information for the MCO.
8. Click **Applications**.
9. Click **Managed Care**.
10. Click **MCO**.

11. Double-click the MCO ID number assigned to the member. The *MCO/Region Maintenance* window displays the MCOs address, phone number, and contact person.
12. Click **File**.
13. Click **Print**.
14. Click **Print Window**.
15. Retrieve a copy of the MCO information from the printer.

Provide the MCO contact information and advise the attorney or insurance carrier to obtain paid claims data from the MCO. Use the following steps for notification:

1. Open Microsoft Word.
2. Click **File**.
3. Click **Open**. Open the file from directory path *L:\Package Three\TPL\Casualty\Letters\Pursuit\Managed Care Program.doc.*
4. Type today's date in the *Date* field.
5. Type the member's name and address.
6. Type the member's name, RID number, and the date of the accident in the *RE:* field.
7. Type the name of the person to whom the letter is being addressed in the *Dear*: field. If the member is a child or minor, address the letter to **Parent(s) of**… or **Guardian of**…
8. Type the amount IHCP has paid in the bolded field in the body of the letter.
9. Type the dates of the MCO enrollment period.
10. Type the name, address, phone number, and contact person associated with the MCO.
11. Type the analyst's name, title, and phone number at the end of the letter.
12. Click the **Spelling and Grammar** icon to check spelling.
13. Click **File**.
14. Click **Print**.
15. Click **OK**.
16. Retrieve copy of letter from the printer.
17. Sign the letter. If sending by mail, make a copy for the case file
18. Send letter by facsimile or by mail to the MCO.

Estate Settlement

Use the following steps to work with the Financial Enhancement Department at the IHCP to settle a casualty case when the member is deceased:

1. Provide the Financial Enhancement Department paid claims data from the *Claims Summary* that includes claims specific to the open case. When the member is deceased, the casualty case belongs to Casualty Unit until the case is settled. Financial Enhancement pursues collection of money not related to the casualty case.
2. Open a case, extract claims, and file a lien when an attorney requests paid claims data for a casualty, malpractice, or workers' compensation case when there is not an active case in TPL. The

attorney tries to determine the TPL lien amount before settlement. Send the paid claims data related to the specific case to the Financial Enhancement Department at the FSSA, even if the member is deceased. FSSA collects against the estate for non-casualty related paid claims.

3. Send correspondence not related to an active case to the Financial Enhancement Department at the FSSA.

Documentation Requests

The IHCP member information is safeguarded pursuant to federal statute (*42 USC 1396a(a)(7)*) and federal regulation (*42 CFR 431.306*). The regulation states, *the agency must obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source.* This blanket requirement applies to all requests, even those from governmental bodies, the courts, or law enforcement officials, (*42 CFR 431.306(e)*).

The TPL Department requires a signed release by the IHCP member or a responsible party because of the confidential nature of a member's medical history and federal law.

There is no distinction in federal or Indiana law concerning a plaintiff or defendant regarding the necessity for a signed release before disclosure of medical records. In all situations, from personal curiosity to a pending personal injury or medical malpractice lawsuit, the member must sign a medical release before any records are disclosed. Send a letter to the requester, explaining the confidential nature of the information and the need for the release. It is then up to the requester to obtain the medical authorization.

The only exception to this rule is when the information requester obtains a court order or a court-issued subpoena requiring the disclosure of information. Comply with a court order or a court-issued subpoena in all circumstances. In the state of Indiana, attorneys can issue subpoenas as officers of the court. An attorney-issued subpoena is not the same as a court-issued subpoena. A medical authorization, signed by the IHCP member, must accompany an attorney-issued subpoena authorizing release of information to the requester.

42 CFR 431.306(f) states that when *a court* issues a subpoena for records, the agency (IHCP) must inform the court of the applicable regulations restricting the disclosure *(42 CFR 431 et. seq., 405 I.A.C. 1-1-1 et. seq.).* The expectation is that the attorney will make the court aware of this issue at the time the attorney seeks the court order.

Even when the IHCP member is the person requesting IHCP records, a release is required. This ensures that the person receiving the information is the same person reflected in the records, and protects the discloser from liability. State law governs this situation by protecting the confidentiality of all medical records, *(Indiana Code 16-39-1-1 et. seq.)* The release must specify the information in *I.C. 16-39-1-4*.

When a member's attorney requests information, check for an authorization to release medical records signed by the IHCP member before releasing the information to the member's attorney. If there is not a signed authorization, contact the attorney for the release.

Present requests for information from the defendant's attorney, or other requester, to the TPL attorney, who reviews the documents to determine the legal requirements of the request and the deadline for responding to the request. If the requester submits a signed authorization with the request, the TPL attorney completes the *Response to Request for Documentation* letter. If an authorization is not included, the TPL attorney requests the medical authorization from the attorney and returns the file to the casualty analyst.

Settlement Calculation

The member's attorney notifies the Casualty Unit when a casualty case settles. The member's attorney can request that the IHCP lien be compromised pursuant to *Pedraza v. Grande*, 712 N.E.2d 1007 (Ind. App. 1999)) or that the IHCP lien be statutorily reduced by applying an allowance for attorney's fees and a pro rata share of attorney's expenses. Refer to *Indiana Code* sections *12-15-8-7* through *12-15-8-7* for additional information. This procedure identifies the State-approved calculation process for both compromise cases and statutory reductions.

1. Start with step 2 for a compromise request. If not, go to step 4.
2. Calculate the *Case Value Percent*
   - Divide the **Settlement Amount** by the **Case Value** and round to four decimal places. This amount represents the *Case Value Percent.*
3. Calculate the *Diminished Lien*
   - Multiply the **Case Value Percent** by the **IHCP Lien** amount and round to two places. This amount represents the new *IHCP Lien* amount.
4. If legal proceedings were initiated go to Step 5. If not, go to Step 6.
5. Calculate the *Attorney Fee Reduction* if legal proceedings were initiated.
   - Multiply the **IHCP Lien** amount by **0.1000** and round to two decimal places, skip to Step 7. This amount represents the *Total Attorney Fees*.
6. Calculate the *Attorney Fee Reduction* if legal proceedings were not initiated.
   - Multiply the **IHCP Lien** amount by **0.7500** and round to two places. This amount represents the *Total Attorney Expenses*.
7. Calculate the *Pro Rata Share of Expenses*
   - Divide the **IHCP Lien** amount by the **Settlement** amount. This amount represents the *Pro Rata Percentage.*
   - Multiply the **Pro Rata Percentage** by the **Total Attorney Expenses**. This amount represents the *Pro Rata Sh*are
8. Subtract the **Total Attorney Fees** and the **Total Attorney Expenses** from the **IHCP Lien Amount**. This amount represents the *Net Due to the IHCP*.

Monthly Case Reviews

The casualty staff must review 90 percent of the cases due for review each month. A Business Objects query runs the last week of each month to extract all cases set for review in the upcoming month.

Review chronological notes in the case file for deceased members to determine any prior claims data sent to the Financial Enhancement Department at the IFSSA. Forward all new claims data to the Financial Enhancement Department and make the appropriate chronological notes in Indiana*AIM*.

A query generates a report used to review of leads each month. The query for leads is the same as the query generated for open cases with one exception. The *Case Status* is **L** for leads to extract only leads for review.

Lead review in Indiana*AIM* is the same as an *Open Case Review*. Refer to the *Case Maintenance Work Flow* for details. Use the following process to review leads:

1. Send a follow-up letter or call the member to determine if another party was responsible for the member's injury, such an auto accident, worker's compensation, or medical malpractice and if the member is pursuing recovery through an insurance company or attorney.
2. Change the *Closed/Review Date* in Indiana*AIM* to generate a follow-up letter in 60 days.
3. Make a chronological note in Indiana*AIM* stating the member or the member's responsible party informed the Casualty Unit that no pursuit is necessary when a member or responsible party contacts the TPL Casualty Unit and reports no other person is at fault. Change the *Lead* status in Indiana*AIM* to *No Further Pursuit*.
4. A query changes the status of all leads to *No Further Pursuit* after 120 days.

Monthly Lead Reviews

Generate the monthly lead review report as follows:

1. Double-click **Business Objects** icon located on the desktop. If the icon is not visible, request Business Objects access from the supervisor.
2. The *User Identification* window displays. Type the appropriate user name and password.
3. Click **OK**.

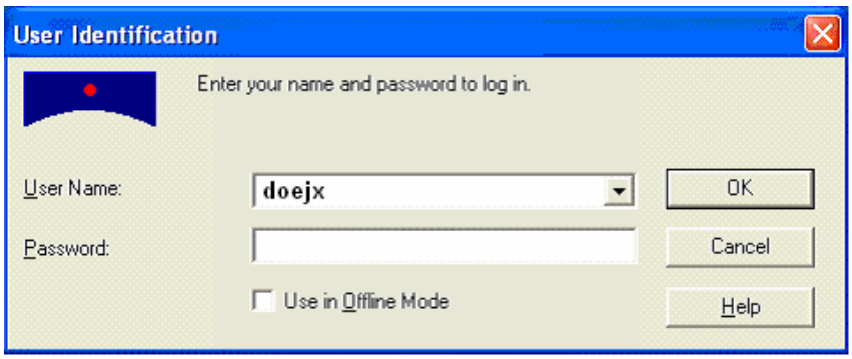


Figure 3.7– User Identification Window

4. The *New Report Wizard* opens automatically when Business Objects opens. Click **Cancel**.

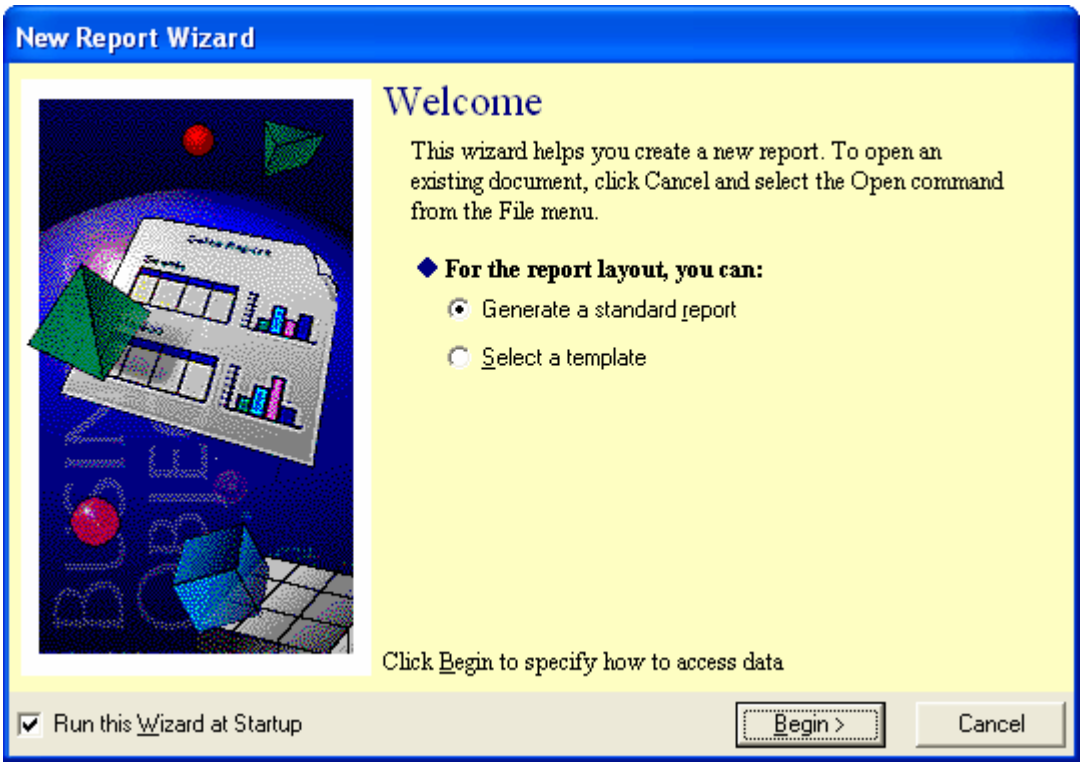


Figure 3.8 – New Report Wizard Window

5. From the Menu tool bar click **File** and **Open**. The **Open** window displays. Navigate to *L:\Package Three\Casualty\Business Objects Queries\Lead Reviews* and click **Open**.

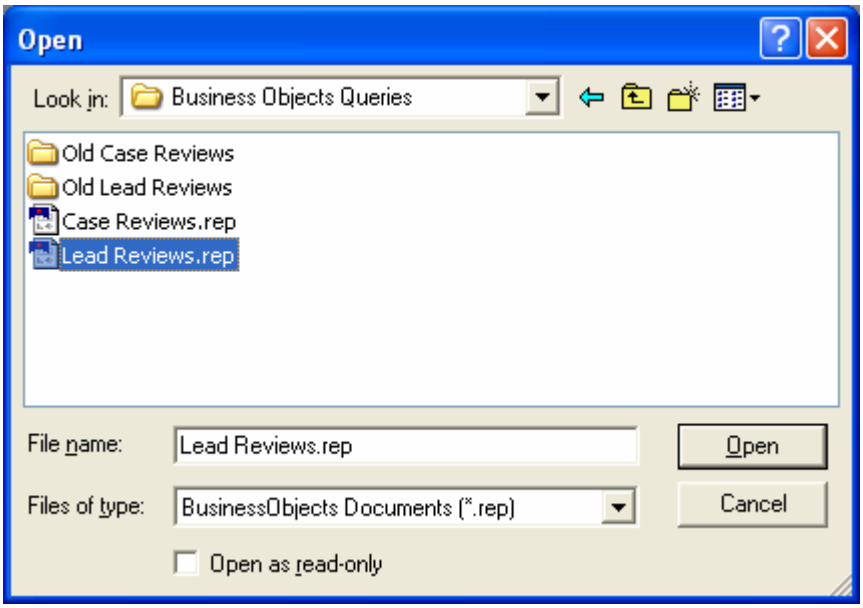


Figure 3.9 – Open Window With Report Selection Example

6. From the *Menu* tool bar click **File**, **Save as**, and save the query in the *Old Lead Reviews* folder using *Month/Year* for the name.

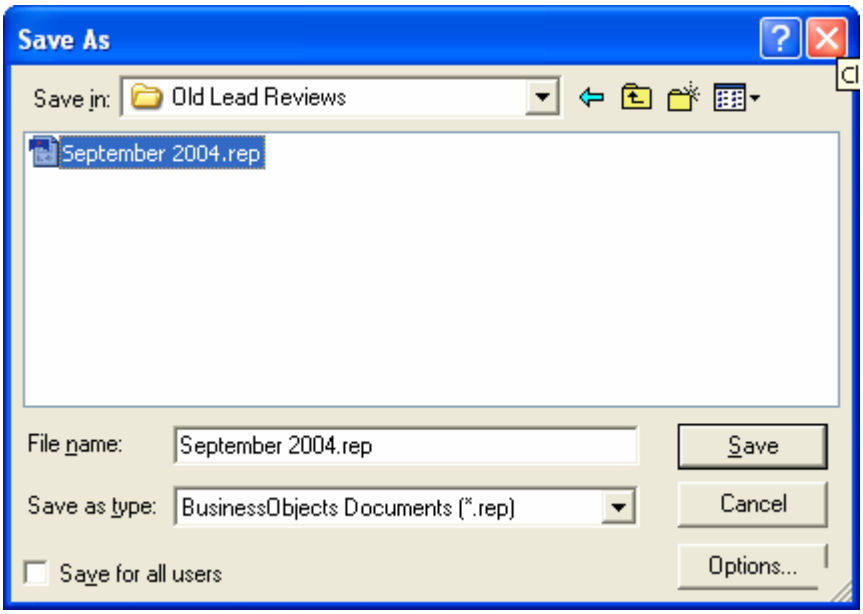


Figure 3.10– Save As Window With Report Name and Location Example

7. From the *Menu* tool bar click **File**, **Send to**, and then click **Broadcast Agent**. The *Send Document to Broadcast Agent* window displays.

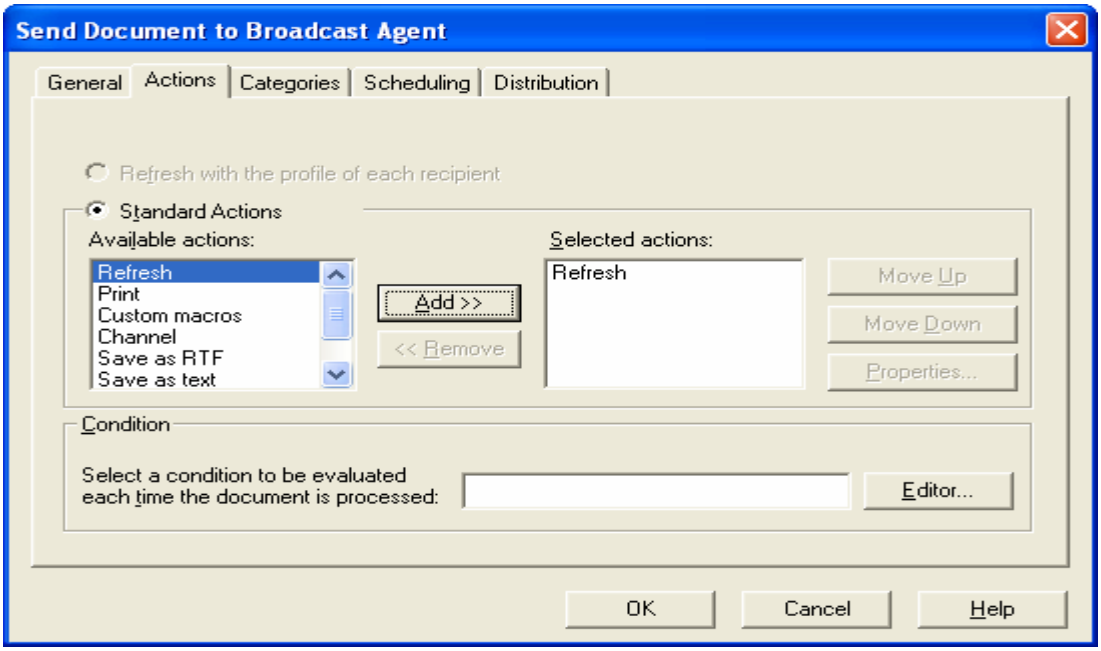


Figure 3.11 – Send Document to Broadcast Agent Action Tab Window

8. Click the **Actions** tab, click **Refresh**, and **Add**. Now click the **Distribution** tab, click the check box marked **Distribute via the Business Objects Repository**, then click the **Add my name to the list**. Click **OK**.

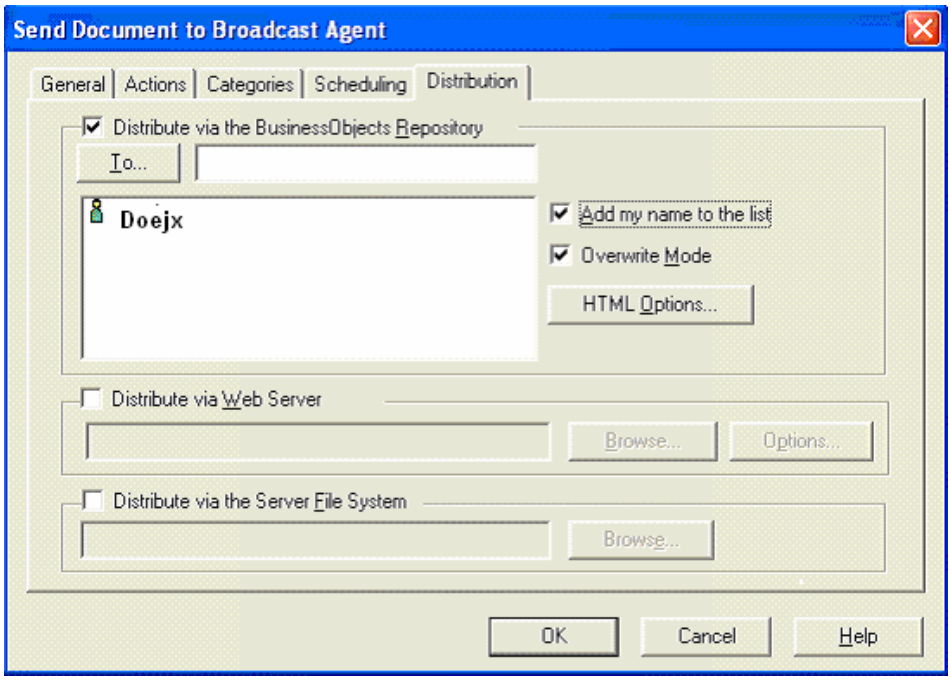


Figure 3.12 – Send Document to Broadcast Agent Distribution Tab Window

Retrieving a Query from the Broadcast Agent

1. From the *Menu* tool bar click **File**, **Retrieve from**, and then **Broadcast Agent**. The *Retrieve* window displays. Click the name of the document for retrieval, then click **Retrieve**.

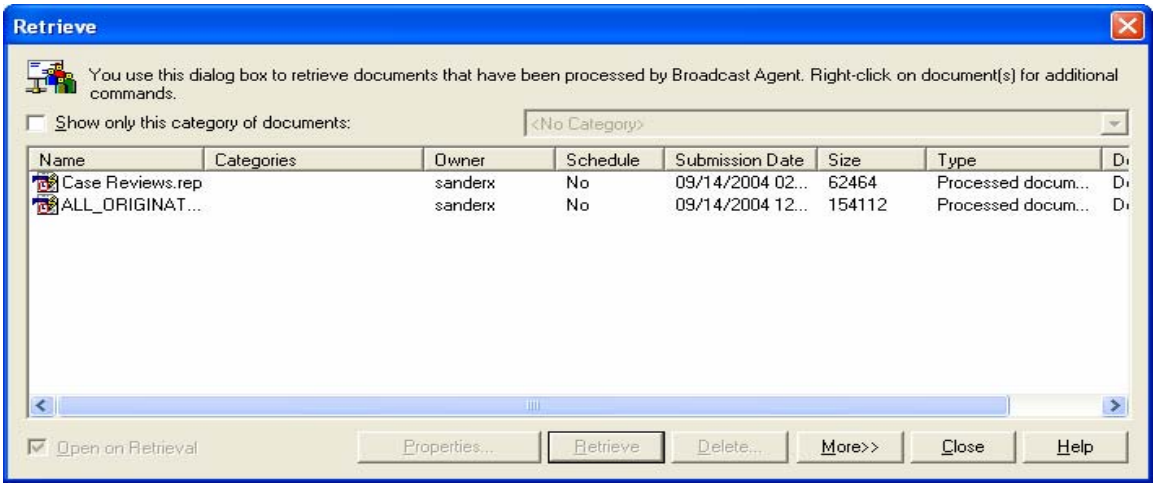


Figure 3.13 – Retrieve Window With Selection Examples

2. The *Import Results* window displays. Click **OK**. The report displays.

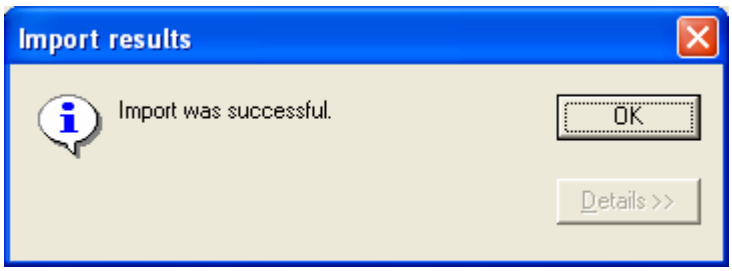


Figure 3.14 – Import results Window

Exporting Data From Business Objects

1. With the report for exporting open, from the *Menu* tool bar click **File** and **Save as**. The *Save As* window displays.

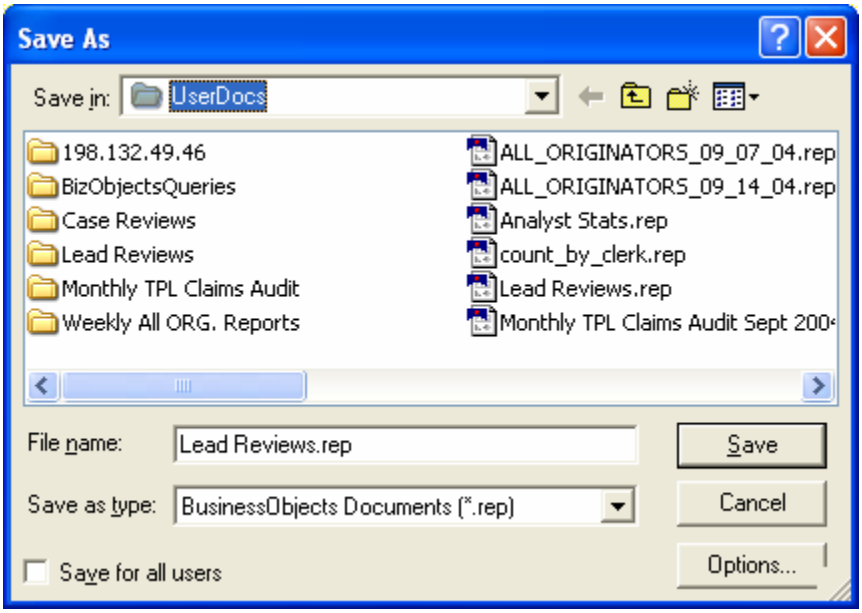


Figure 3.15 – Save As Window with Report Name and Location Example

2. At the *Save As* window, click the drop-down box to display the *Save in:* drop-down box, and click **Desktop**. In the *File name:* field, use the *Month/Year* for the file name. In the *Save as type:* field click *Rich text format [*.rtf]*. Click **Save**.

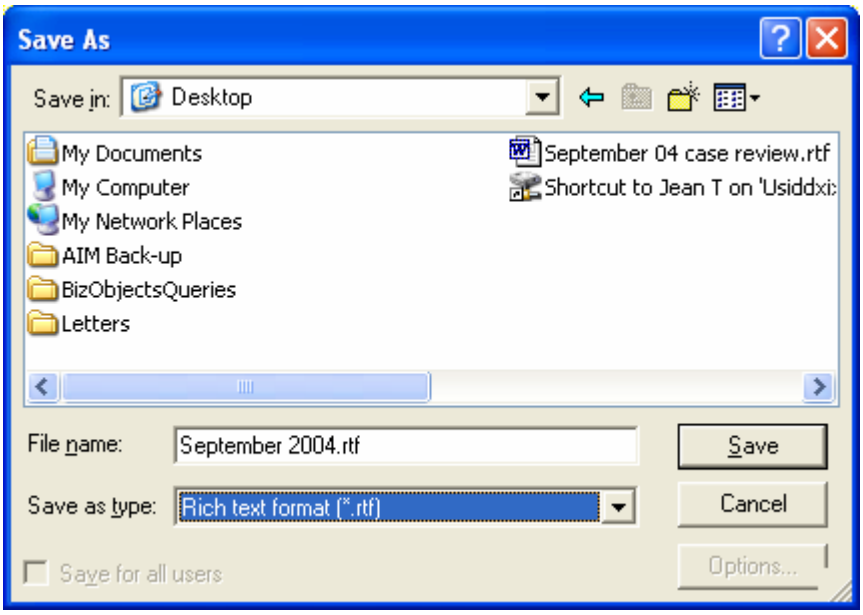


Figure 3.16 – Save As Window With New Name and File Type Examples

3. Navigate to the desktop and locate the file just saved. Open the file using Microsoft word.

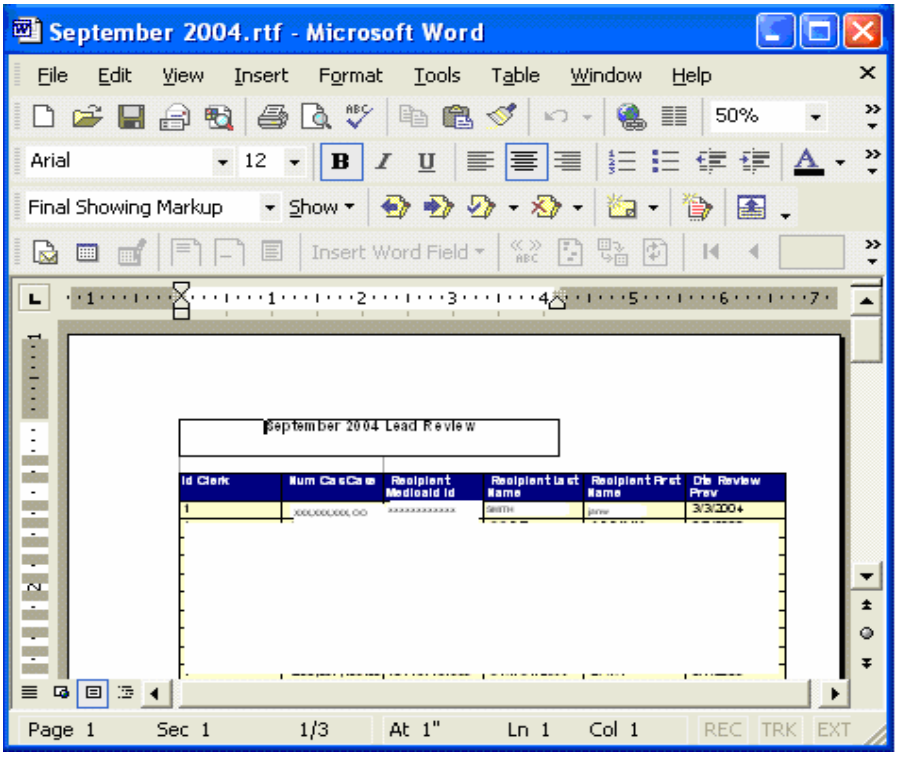


Figure 3.17 – Example of Word Spreadsheet in Rich Text Format

4. Open a new Microsoft Excel workbook.

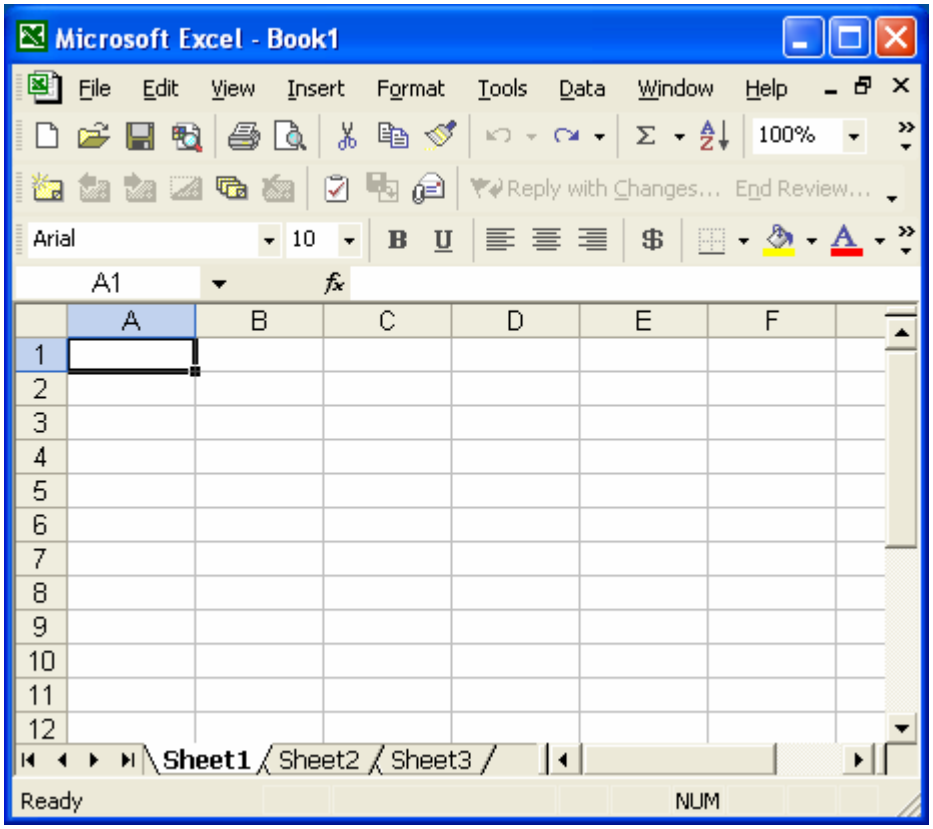


Figure 3.18 – Example of Excel Workbook Sheet

5. Return to the open Word document. From the *Menu* tool bar, click **Edit**, **Select All**, **Edit**, and **Copy**.

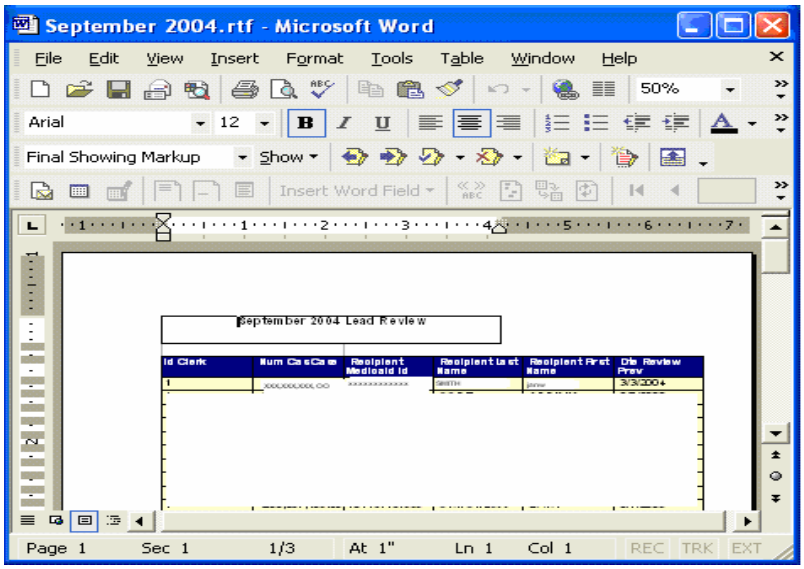


Figure 3.19 – Example of Word Spreadsheet in Rich Text Format

6. Return to the open Excel workbook. From the *Menu* tool bar, click **Edit**, **Paste**. The Business Objects data is now available in Microsoft Excel.

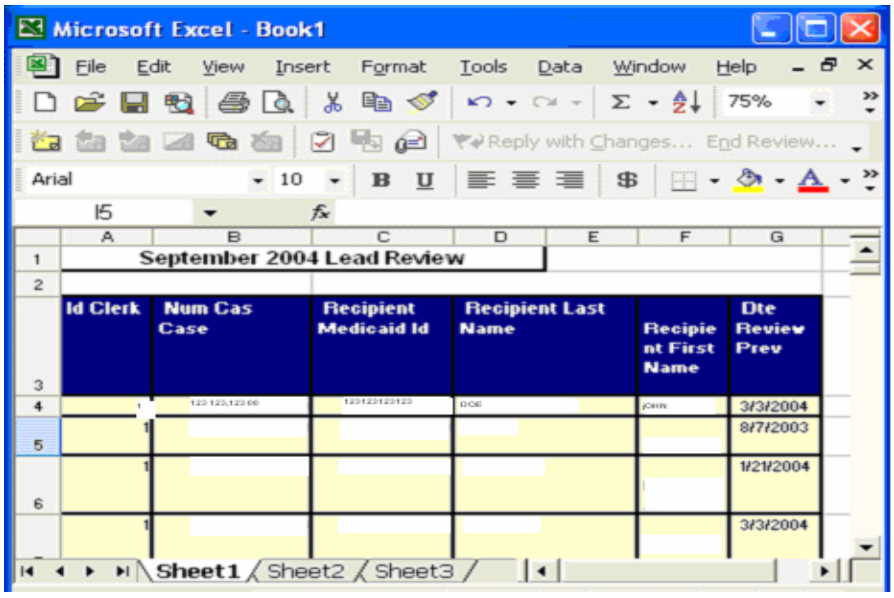


Figure 3.20 – Example of Excel Spreadsheet Created With Data Imported From Word

Sorting Leads for Distribution

1. After exporting *Lead* reviews to Microsoft Excel, sort by the Casualty analysts number.
2. Cut and paste the data into the spreadsheet at *L:\Package Three\Casualty\Lead Reviews\Lead Reviews 04* under the tab for the current month.

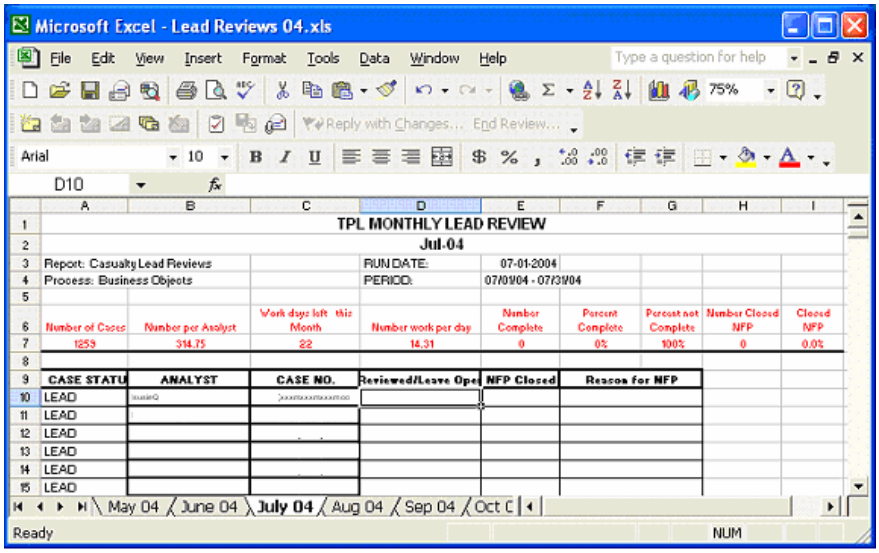


Figure 3.21 – Example of Lead Reviews Spreadsheet Created From Imported Data

3. Sort the spreadsheet by Casualty analyst and a give a hard copy of case reviews for the month to each analyst. Table 3.1 identifies analysts as assigned by Indiana*AIM*.

Table 3.1 – Indiana*AIM* Casualty IDs

TPL Casualty Analyst		Indiana*AIM* ID
Shantel Silnes	=	1
Michelle Jones	=	2
Sharon Hamby	=	3
Rob Sanders	=	4
Rebecca Siewert	=	5

Monthly Case Reviews

The casualty staff must review 90 percent of cases due for review each month. A Business Objects query is ran on the first day of each month to extract all cases for review for that month.

Generate the query as follows:

1. Click **Business Objects** icon on the desktop. If the Business Objects icon is not available on the desktop, request access from supervisor.
2. The *User Identification* window displays. Type the user name and password and click **OK**.

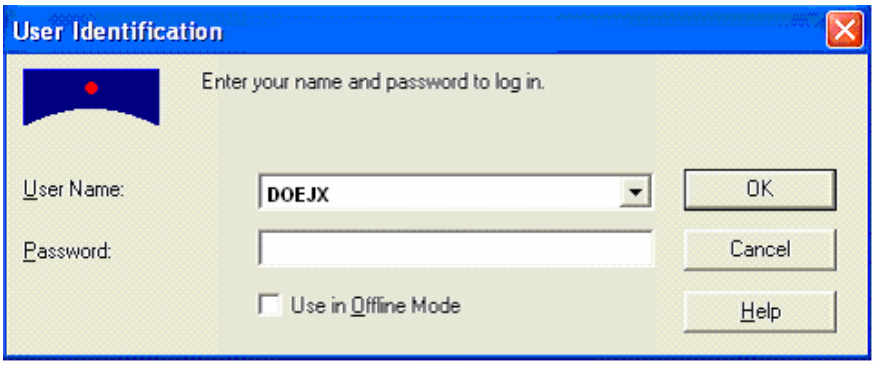


Figure 3.22 – User ID Window

3. When *Business Objects* opens, the *New Report Wizard* automatically opens. Click **Cancel**.

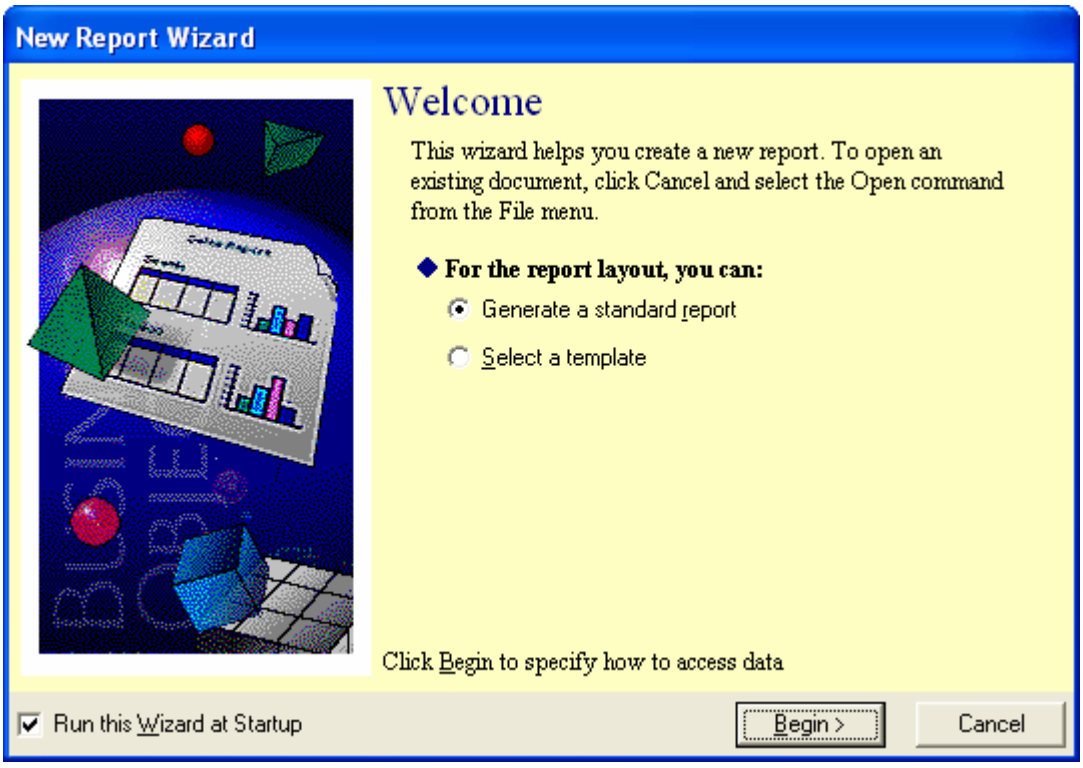


Figure 3.23 – New Report Wizard Window

4. From the *Menu* tool bar click **File**, then **Open**. The *Open* window displays. Navigate to *L:\Package Three\Casualty\Business Objects Queries\Case Reviews* and click **Open**.

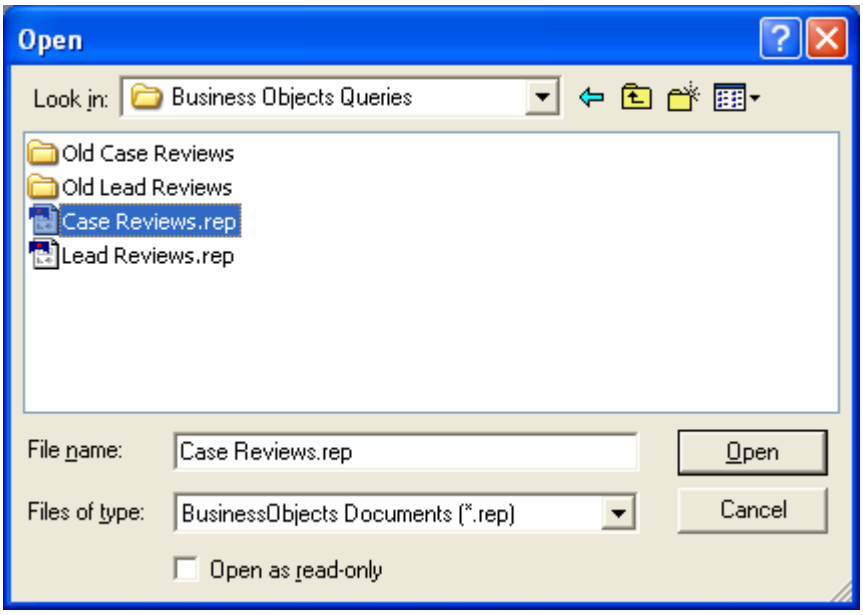


Figure 3.24 – Open Window With Report Selection Example

5. From the *Menu* tool bar click **File**, **Save As**, and save the query in the *Old Case Reviews* folder using the appropriate month/year for the name.

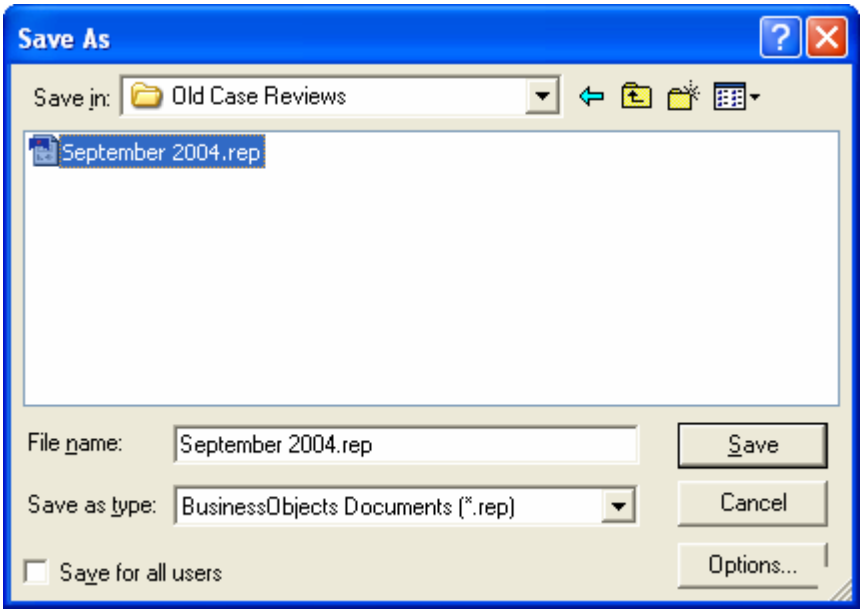


Figure 3.25 – Save As Window With Report Name and Location Example

6. From the *Menu* tool bar click **File**, **Send to**, then click **Broadcast Agent**. The *Send Document to Broadcast Agent* window displays.

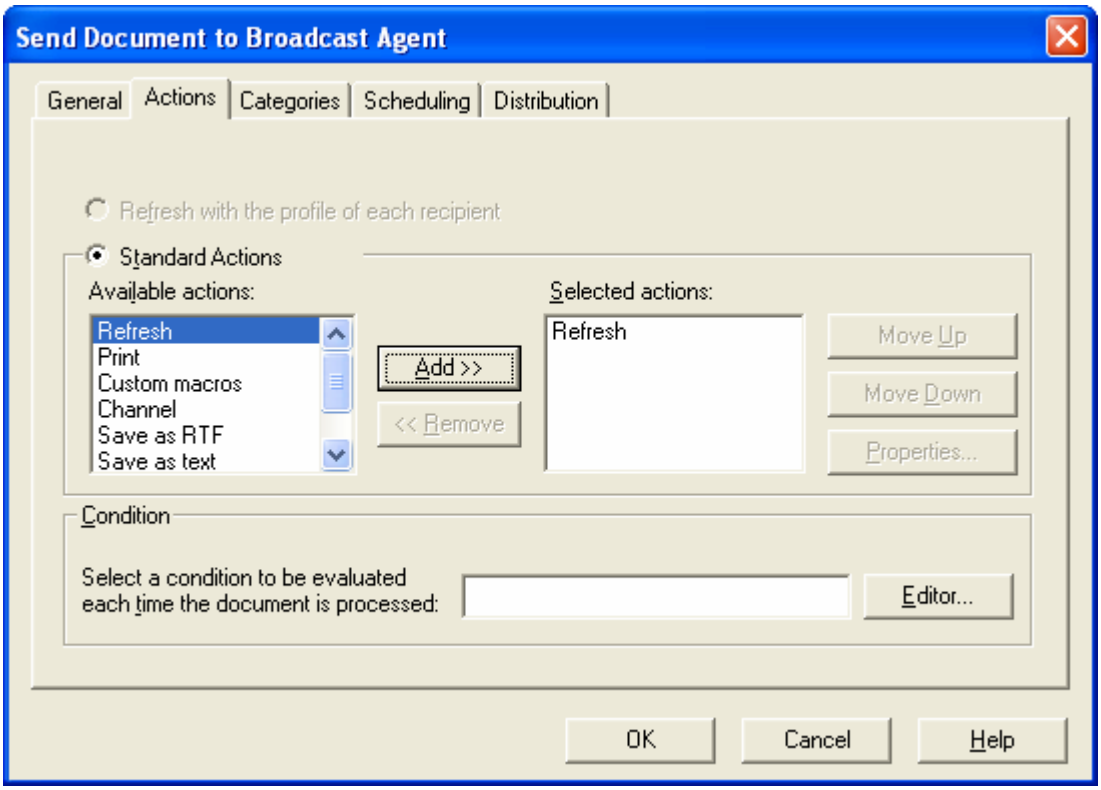


Figure 3.26 – Send Document to Broadcast Agent Action Tab Window

7. Click the **Actions** tab, click **Refresh**, and then **Add**. Click the **Distribution** tab, click the check box marked *Distribute via the Business Objects Repository*, then click **Add my name to the list** check box. Click **OK**.

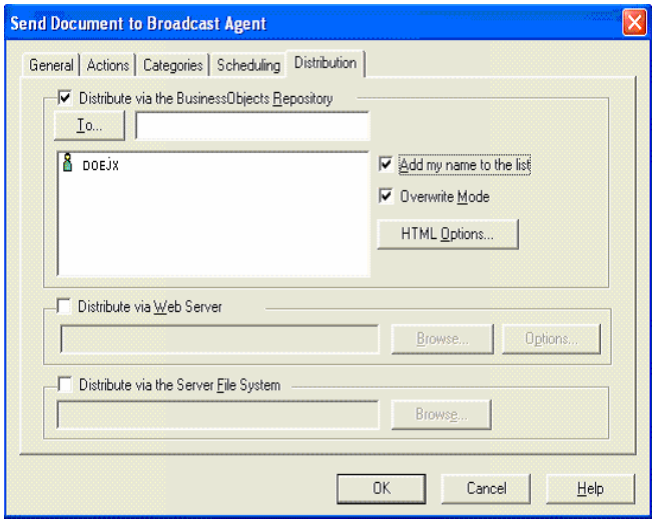


Figure 3.27 – Send Document to Broadcast Agent Distribution Tab Window

Retrieving a Query from the Broadcast Agent

1. From the *Menu* tool bar click **File**, **Retrieve From**, and then **Broadcast Agent**. The *Retrieve* window displays. Click the document for retrieval and then click **Retrieve**.

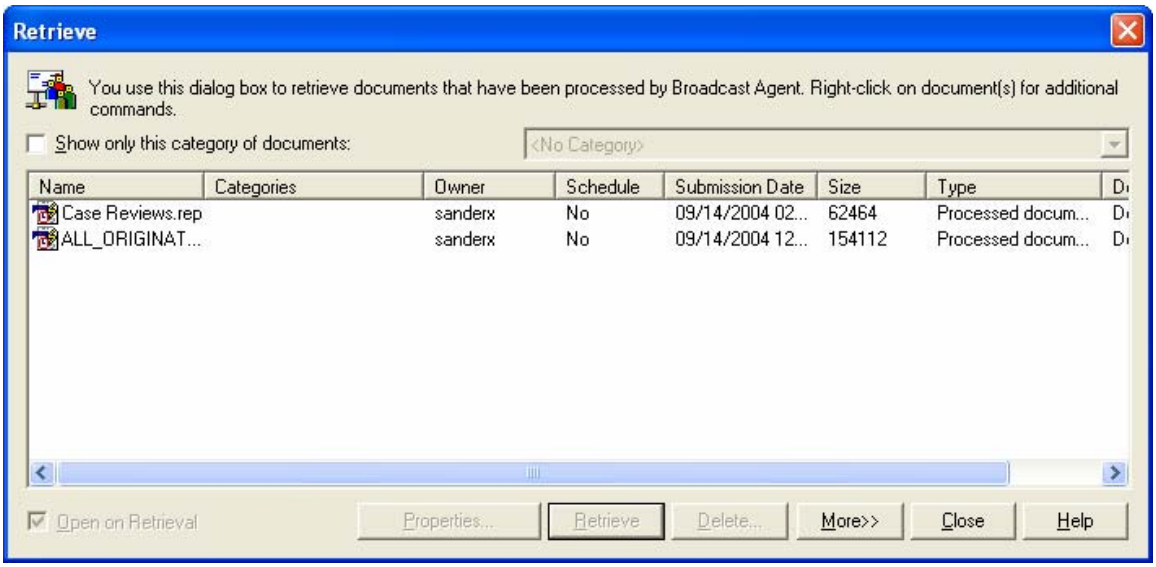


Figure 3.28 – Retrieve Window Selection Example

2. The **Import results** window displays. Click OK. The report displays.

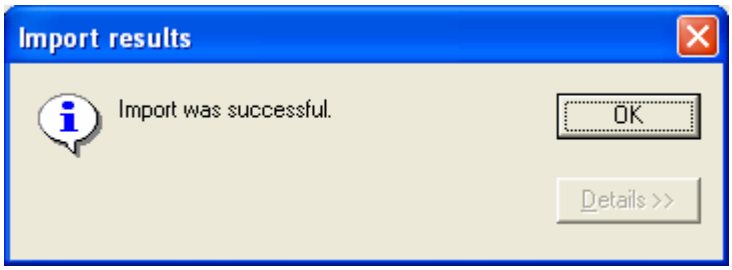


Figure 3.29 – Import results Window

Exporting Data From Business Objects

1. With the report for exporting open, from the *Menu* tool bar click **File**, **Save As**. The *Save As* window displays.

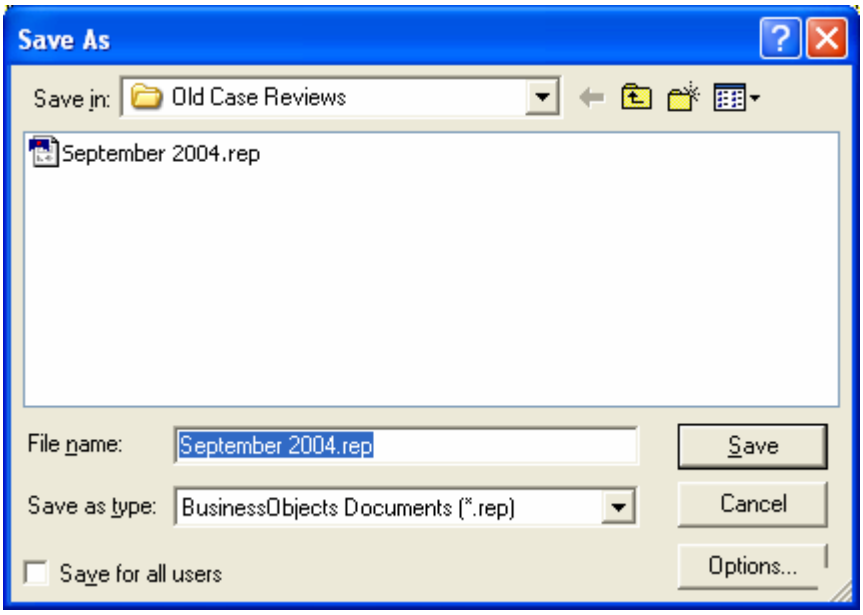


Figure 3.30 – Save As Window Showing Report Name and Location Example

2. Click the *Save in* field drop-down menu and click **Desktop**. In the *File name:* field, type the appropriate month/year as the file name. Click the *Save as type:* drop-down menu and click **Rich Text Format**. Click **Save**.

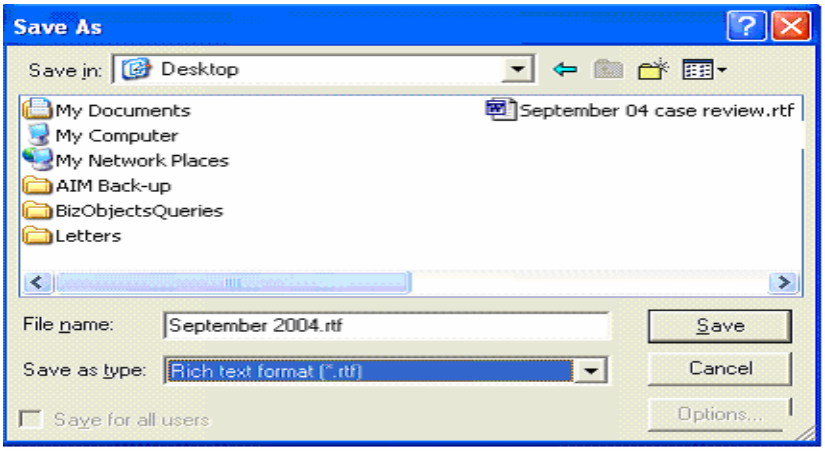


Figure 3.31 – Save As Window Showing New Name and File Type Example

3. Navigate to the desktop and locate the file just saved. Open the file using Microsoft Word.

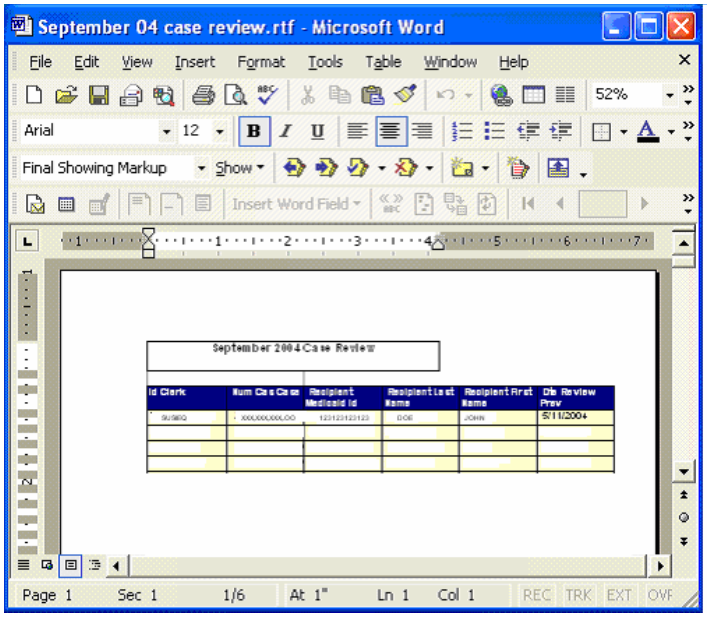


Figure 3.32 – Case Review Word Spreadsheet in Rich Text Format

4. Open a new Microsoft Excel workbook.

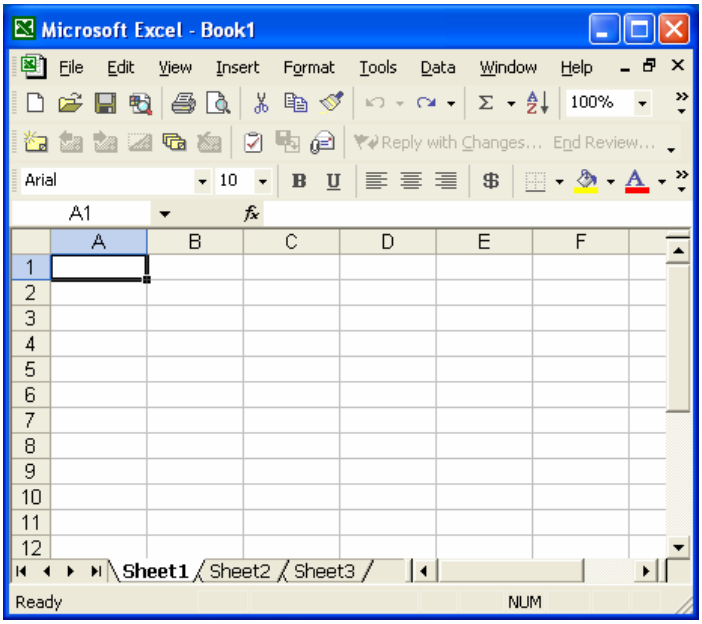


Figure 3.33 – Example of Excel Workbook Sheet

5. Return to the open document in Microsoft Word. From the *Menu* tool bar, click **Edit**, **Select All**, **Edit**, **Copy**.

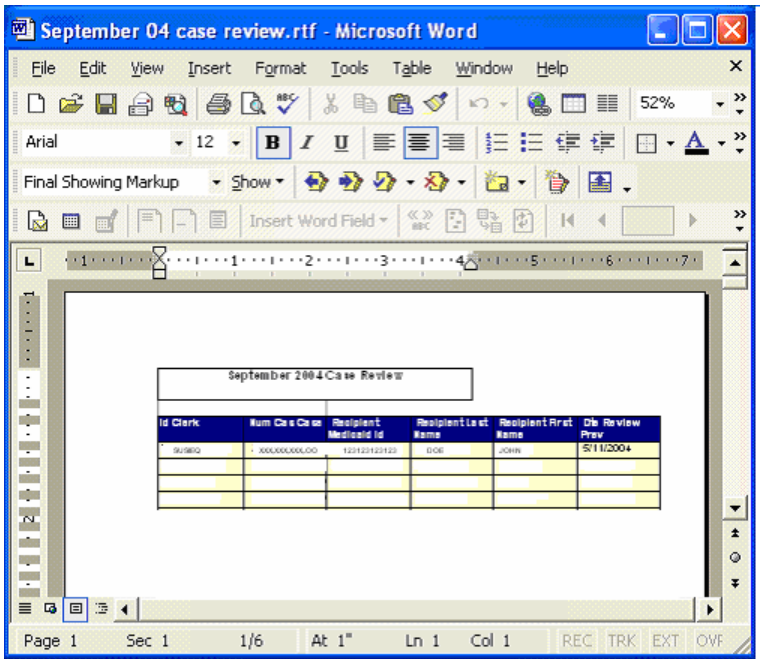


Figure 3.34 – Word Spreadsheet in Rich Text Format

6. Return to the open Excel workbook. From the *Menu* tool bar, click **Edit**, **Paste**. The Business Objects data is now available in Microsoft Excel.

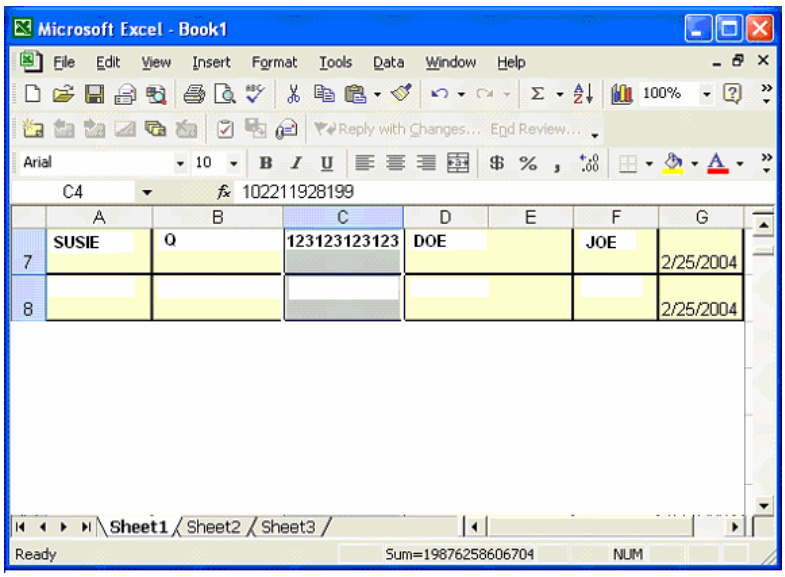


Figure 3.35 – Example of Excel Spreadsheet Created from Data Imported from Word

Sorting Cases for Distribution to the Casualty Analyst

1. After exporting case reviews to Microsoft Excel, divide evenly between the Casualty analysts. Reassign cases as appropriate for distribution.
2. After evenly distributing the cases in the spreadsheet, cut and paste into the spreadsheet at *L:\Package Three\Casualty\Case Review\2004 Case Reviews*. Click the tab for the current month and paste the data.

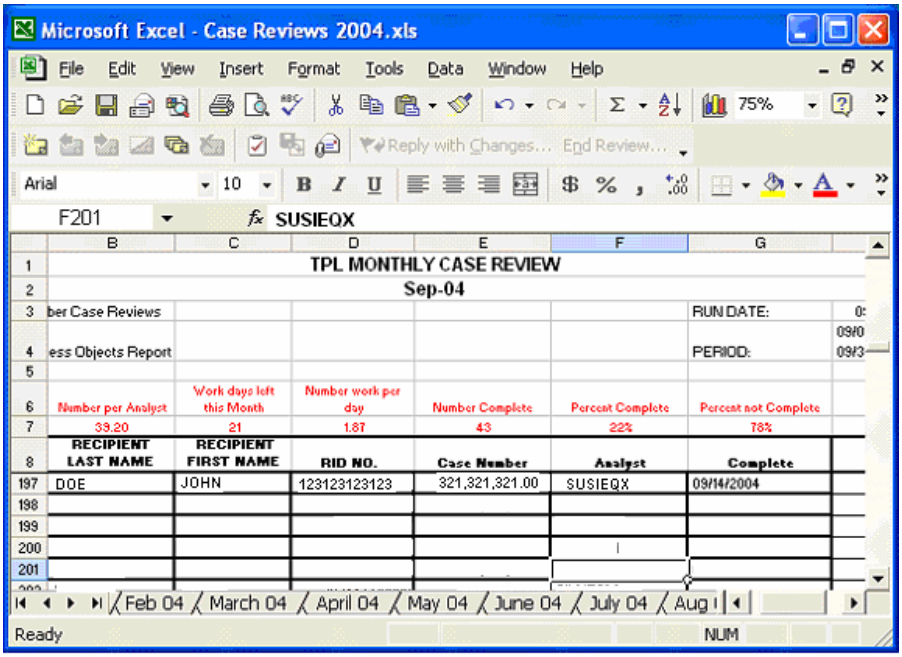


Figure 3.36 – Example of Lead Review Spreadsheet Created From Imported Data

3. Sort the spreadsheet by Casualty analyst and deliver a hard copy to each analyst.

Section 4: Letters

Overview

This section provides a sample of each letter used in the TPL Casualty Unit. Also included is a sample of the system-generated accident/trauma letter and the questionnaire that accompanies each letter. Table 4.1 is a quick reference to all letters and the use. The letters are listed by the name in alphabetical order.

Table 4.1 – Casualty Letters

Letter	Purpose	File Location
Attorney Settlement & Calculation	This letter provides the final amount due to settle IHCP liens.	L/Package Three/Casualty/Attny Settlmt & Calcs.doc
Attorney Status Update – Additional Claims Paid	This letter requests a status update from the attorney and includes the new claims paid amount.	L/Package Three/Casualty/Attny Status Update Addl Claims Pd.doc
Attorney Status Update – No Additional Claims Paid	This letter requests a status update from the attorney when there are no new paid claims.	L/Package Three/Casualty/ Attny Status Update No Addl Claims Pd.doc
Defense Attorney Paid Claims Information	This letter provides the defense attorney with paid claims information.	L/Package Three/Casualty/Def Attny Pd Claims Info.doc
Defandant Notice	This letter notifies the defense attorney of the IHCP lien.	L/Package Three/Casualty/Defendant Notice.doc
HIPPA Compliant FAX Cover Sheet	This is the HIPAA compliant cover sheet for faxes sent from the Casualty Unit.	L/Package Three/Casualty/HIPPA FAX Cover Sheet.doc
Initial Attorney Notice	This letter notifies the member's attorney of the IHCP lien.	L/Package Three/Casualty/Initial Attny Notice.doc
Initial Insurance Company Notice	This letter notifies the insurance company of the IHCP lien.	L/Package Three/Casualty/Initial Ins Co Notice.doc
Insurance Company Status Update – Additional Claims Paid	This letter requests a status update and includes the new paid claims amount.	L/Package Three/Casualty/Ins Co Status Updae Addl Claims Pd.doc
Insurance Company Status Update – No Additional Claims Paid	This letter requests a status update when there are no new paid claims.	L/Package Three/Casualty/Ins Co Status Update No Addl Claims Pd.doc
Managed Care – No Fee For Service Claims	This letter notifies the MCO of the member's accident when there are no fee for service claims.	L/Package Three/Casualty/Mgd Care Ltr No Fee For Service Claims.doc
Managed Care – With Fee For Service Claims	This letter notifies the MCO of the member's accident when there are fee for service and MCO claims.	L/Package Three/Casualty/ Mgd Care Ltr With Fee For Service Claims.doc
Member Not Found	This letter notifies the interested party that the individual identified is not an	L/Package Three/Casualty/Member Not

Table 4.1 – Casualty Letters

Letter	Purpose	File Location
	IHCP member.	Found.doc
Indiana Patient Compensation Fund Notice	This letter notifies the Indiana Patient Compensation Fund of the IHCP lien.	L/Package Three/Casualty/____.doc
No Further Pursuit	This letter notifies the interested party that there are no paid claims for the identified member.	L/Package Three/Casualty/No Further Pursuit.doc
Pursuit – With Statute of Limitations	This letter requests additional information from the member concerning the accident and advised of the two-year statute of limitations.	L/Package Three/Casualty/Member Pursuit With Statute of Limitations.doc
Compromise Request	This letter notifies the attorney of the information required to request a compromise of the lien amount.	L/Package Three/Casualty/Request For Compromise.doc
Status Update – Referral to Attorney General	This letter notifies the interested party of referral of the case to the attorney general for further action.	L/Package Three/Casualty/Status Update Referral to Attorney General.doc
Response to Subpoena for Claim Information	This letter accompanies information requested by subpoena.	L/Package Three/Casualty/Response to Subpoena for Claim Info.doc

<date>

<name>
<law firm>
<address>
<city, state, ZIP code>

RE: IHCP member:
RID number:
Incident date:

Dear <name>:

IC 12-15-8-7 and *12-15-8-8*, requires the Indiana Health Coverage Programs (IHCP) to pay attorney fees at 7.5 percent and a pro rata share of expenses, or at 10 percent when a suit is filed. The following calculation supports the net lien amount due to the IHCP.

Settlement Calculations		
Settlement amount		
Attorney expenses		
IHCP lien		
Attorney fees	-	
Pro rata share	-	
Net to IHCP		

Make checks payable to the *Indiana Health Coverage Programs* and mail to the following address:

EDS Third Party Liability
PO Box 7262
Indianapolis, IN 46207-7262

If you have questions or concerns, contact us at (317) 488-<XXXX> or 1-800-457-4510.

Sincerely,

<analyst>
Casualty Analyst

Figure 4.1 – Attorney Settlement & Calculation Letter

<date>

<attorney>
<name>
<address>
<city, state, ZIP code>

RE: IHCP member:
RID number:
Incident date:

Dear <name>:

Since our last follow up the Indiana Health Coverage Programs (IHCP) has paid additional claims related to this incident. The subrogation amount has increased to **$XX.XX.**

Please provide the status of this case.

Contact us at (317) 488-<XXXX> or 1-800-457-4510 if you have any questions.

Sincerely,

<analyst>
Casualty Analyst

Figure 4.2 – Attorney Status Update Additional Claims Paid

<date>

<attorney>
<name>
<address>
<city, state, ZIP code>

RE: IHCP member:
RID number:
Incident date:

Dear <name>:

Since our last follow up the Indiana Health Coverage Programs (IHCP) has not paid additional claims related to this incident. The subrogation amount remains **$XX.XX.**

Please provide the status of this case.

Contact us at (317) 488-<XXXX> or 1-800-457-4510 if you have any questions.

Sincerely,

<analyst>
Casualty Analyst

Figure 4.3 – Attorney Status Update No Additional Claims Paid

<date>

<attorney>
<firm>
<address>
<city, state, ZIP>

RE: IHCP member:
RID number:
Incident date:

Dear <name>:

Enclosed is paid claim information from the Indiana Health Coverage Programs (IHCP) for the above IHCP member.

If actual copies of the claims are required, request those directly from the provider of services.

If you have questions or concerns, contact us (317) 488-XXXX or 1-800-457-4510.

Sincerely,

<analyst>
Casualty Analyst

Enclosure

cc: <member's attorney>

Figure 4.4 – Defense Attorney Paid Claims Information

<name>
<address>
<city, state, ZIP>

RE: **IHCP member:** <name>
RID number: <number>
Incident date: <date>

Dear <name>:

The EDS Third Party Liability Department received information naming you as a defendant in legal action initiated by the above Indiana Health Coverage Programs (IHCP) member. The IHCP may pay, or may already have paid, for medical services related to this incident.

If you, or your insurance carrier, are found liable for the medical expenses related to the incident, the IHCP is entitled to reimbursement for the medical expenses paid for this member. The Indiana Family and Social Services Administration (FSSA) will pursue this case in accordance with the provisions set forth in IC 12-15-8-1 through 12-15-8-4, 42 USCA § 1396a(A)(25), 42 CFR § 433.135, and FSSA regulations 405 IAC 1-1-1, 1-1-13, and 1-1-15.

Notice of this action was sent to everyone involved. If you have questions or concerns, contact us at (317) 488-XXX or 1-800-457-4510.

Sincerely,

Figure 4.5 – Defendant Notice

To: Attn: <name> From: <name>

Fax: <xxx-xxx-xxxx> Fax: 317-488-5217

Phone: Phone: 317-488-<XXXX>

No. of pages including cover: <XX> Date: <Date>

Re: <subject>

☐ Urgent ☒ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

This facsimile transmission (and attachments) contains protected health information (PHI) from EDS, and is covered by the Electronic Communications Privacy Act, 18 U.S.C. §2510-2521 and the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, which is intended only for the use of the individual or entity named in this fax transmission. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited. Any unintended recipient should contact the EDS Privacy Unit by telephone at (317) 488-5189 immediately and destroy the original message.

Figure 4.6 – HIPAA Compliant Fax Cover Sheet

<Date>

<Attorney>
<Firm>
<Address>
<City, State, ZIP>

RE: **IHCP member:** <name>
RID number: <RID number>
Incident date: <date>

Dear <name>:

The EDS Third Party Liability Department received information that you represent the Indiana Health Coverage Programs (IHCP) member related to the above incident date. The IHCP has paid <**$0.00**> to date for medical expenses related to this incident.

Federal and state statutory and regulatory provisions allow the Indiana Family and Social Services Administration (FSSA) to assert and pursue a lien when a third party is legally responsible for payment of the medical expenses incurred by an IHCP member. The FSSA will pursue this case according to *Ind. Code § 12-15-8-1, et. seq.*, FSSA regulations *405 I.A.C. 1-1-1, 1-1-13*, and *1-1-15, 42 USCA § 1396a(A)(25)*, and *42 CFR § 433.135*.

Forward a copy of the complaint, if one has been filed. Provide all insurance information applicable to your client's claim, including the defendant's name, insurance information, and attorney. You must also provide an authorization form to release medical information signed by your client or the client's representative. This information will allow the IHCP to advise all parties of the lien interests related to this case.

We periodically verify claim payments. Contact our office prior to making any settlement disbursements. We will advise you of any amendments to this case.

If you have any questions or concerns contact our office at (317) 488-<XXXX> or 1-800-457-4510.

Sincerely,

<name>
Casualty Analyst

Figure 4.7 – Initial Attorney Notice

<date>

<insurance company>
<Name>
<address>
<city, state, ZIP code>

Re: IHCP member/RID number:
Insured:
Incident date:
Policy or claim number:

Dear <name>:

The Indiana Family and Social Services Administration (IFSSA) is pursuing a lien related to the above incident. The total amount paid to date for the IHCP member's incident-related claims is **$**<XX.XX>**.**

Please provide insurance information related to this incident including coverage, policy limits, and medical payments coverage.

Statutes *42 CFR 411.26(b)* and *42 U.S.C.A. §1396a(A) (25)* requires the IHCP to pursue a liable third party for damages.

Indiana statutes, *IC 12-15-29-4* and *12-15-29-5*, provide that insurers make payments directly to the IHCP. Payment to a person or an entity other than the IHCP does not release the insurer from payment of an IHCP claim. It is your company's responsibility to reimburse the IHCP for the outstanding lien amount. Contact our office before making any settlement disbursements.

Make lien reimbursements payable to the *IHCP* and send to the following address:

EDS Third Party Liability
P.O. Box 7262
Indianapolis, IN 46207-7262

If you have any questions or concerns contact us at (317) 488-<XXXX> or 1-800-457-4510.

Sincerely,

<analyst>
Casualty Analyst

Figure 4.8 – Initial Insurance Company Notice

<date>

<Ins. Co.>
<name>
<address>
<city, state, ZIP code>

RE: IHCP member:
RID number:
Incident date:

Dear <name>:

Since our last follow up the Indiana Health Coverage Programs (IHCP) has paid additional claims related to this incident. The subrogation amount of **$XX.XX** has increased to **$XX.XX.**

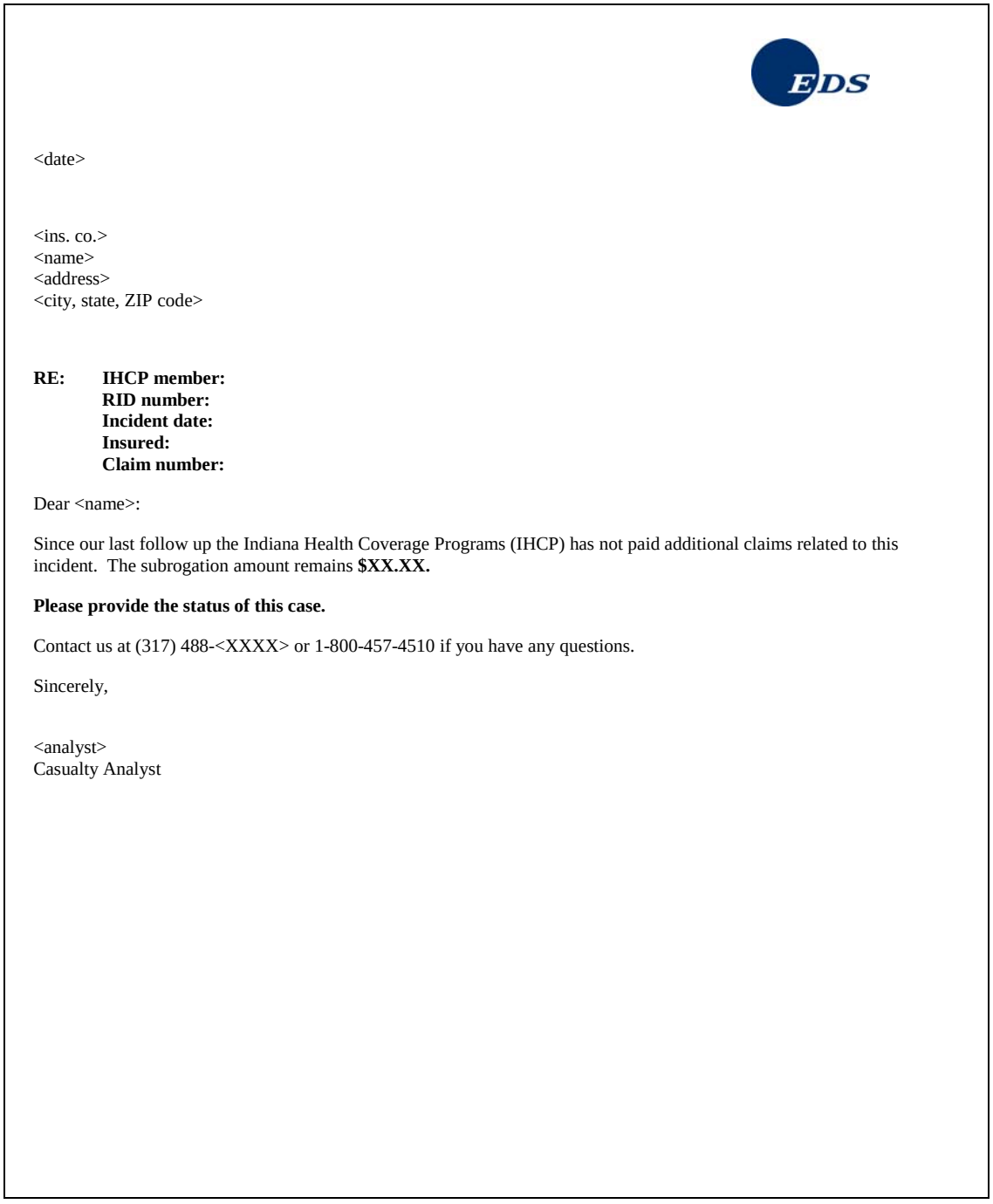
Please provide the status of this case.

Contact us at (317) 488-<XXXX> or 1-800-457-4510 if you have any questions.

Sincerely,

<analyst>
Casualty Analyst

Figure 4.9 – Insurance Company Status Update Additional Claims Paid



<date>

<ins. co.>
<name>
<address>
<city, state, ZIP code>

RE: IHCP member:
RID number:
Incident date:
Insured:
Claim number:

Dear <name>:

Since our last follow up the Indiana Health Coverage Programs (IHCP) has not paid additional claims related to this incident. The subrogation amount remains **$XX.XX.**

Please provide the status of this case.

Contact us at (317) 488-<XXXX> or 1-800-457-4510 if you have any questions.

Sincerely,

<analyst>
Casualty Analyst

Figure 4.10 – Insurance Company Status Update No Additional Paid Claims

<date>

<attorney>
<firm>
<address>
<city, state, ZIP>

RE: IHCP member:
RID number:
Incident date:

Dear <name>:

The EDS Third Party Liability Department received information that you represent the above member. To date, the IHCP has not paid fee-for-service medical expenses related to the above incident.

This member is enrolled in a managed care organization. Contact the MCO listed below for paid claim information:

Managed Health Services
1099 N. Meridian Street
Suite 320
Indianapolis, IN 46204
Phone: (317) 630-2833

Federal and state statutory and regulatory provisions require the Indiana Family and Social Services Administration (IFSSA) to pursue a lien when a third party is responsible for payment of medical expenses incurred by an IHCP member. The IFSSA will pursue this case in accordance with the provisions set forth in *IC 12-15-8-1, et. seq.*, IFSSA regulations *405 IAC 1-1-1, 1-1-13*, and *1-1-15, 42 USCA § 1396a(A)(25)*, and 42 CFR § 433.135.

If you have questions or concerns, contact us at 317-488-<XXXX> or 1-800-557-4510.

Sincerely,

<analyst>
Casualty Analyst

Cc: MCO

Figure 4.11 – Managed Care Letter No Fee For Service Claims

<date>

<attorney>
<firm>
<address>
<city, state, ZIP>

RE: IHCP member:
RID number:
Incident date:

Dear <name>:

The EDS Third Party Liability Department received information that you represent the above member. To date, the IHCP has paid <**$XX.XX**> in fee-for-service medical expenses related to the above incident.

Contact the MCO listed below for paid claim information from <date>through <date>:

Managed Health Services
1099 N. Meridian Street
Suite 320
Indianapolis, IN 46204
Phone: (317) 630-2833

Federal and state statutory and regulatory provisions require the Indiana Family and Social Services Administration (IFSSA) to pursue a lien when a third party is responsible for payment of medical expenses incurred by an IHCP member. The IFSSA will pursue this case in accordance with the provisions set forth in *IC 12-15-8-1, et. seq.*, IFSSA regulations *405 IAC 1-1-1, 1-1-13*, and *1-1-15, 42 USCA § 1396a(A)(25)*, and 42 CFR § 433.135.

If you have questions or concerns, contact us at 317-488-<XXXX> or 1-800-557-4510.

Sincerely,

<analyst>
Casualty Analyst

Cc: MCO

Figure 4.12 – Managed Care Letter With Fee For Service Claims

<date>

<name
<company name>
<address>
<City, State, ZIP>

RE: **Accident report on:** <name>

Dear <name:>

Indiana Health Coverage Programs (IHCP) is unable to identify the above person as an IHCP member.

The IHCP only pursues cases involving active members when a liable third party is identified and when accident-related claims have been paid.

If you have any questions or concerns, contact our office at 317-488-<XXXX> or 1-800-457-4510.

Sincerely,

<name>
Casualty Analyst

Figure 4.13 – Member Not Found

<date>

<name>

Chief Legal Counsel
Attention: Patient Compensation Fund
311 W. Washington Street, Suite 300
Indianapolis, IN 46204-2787

RE: IHCP member:

RID number:

Incident date:

Defendant:

Dear <name>:

We have been notified that legal action, initiated by the above Indiana Health Coverage Programs (ICHP) member is pending against the Indiana Patient Compensation Fund for the above incident. To date, the IHCP has paid **$<XX.XX>** for claims related to this incident.
The IHCP has a lien in all cases when a third party resource is liable for payment of expenses incurred by the IHCP member. The recipient's attorney was notified of the IHCP lien.
Please make checks payable to the *IHCP*. Direct all lien reimbursements and any correspondence to the following address:

EDS Third Party Liability
P.O. Box 7262
Indianapolis, IN 46207-7262.

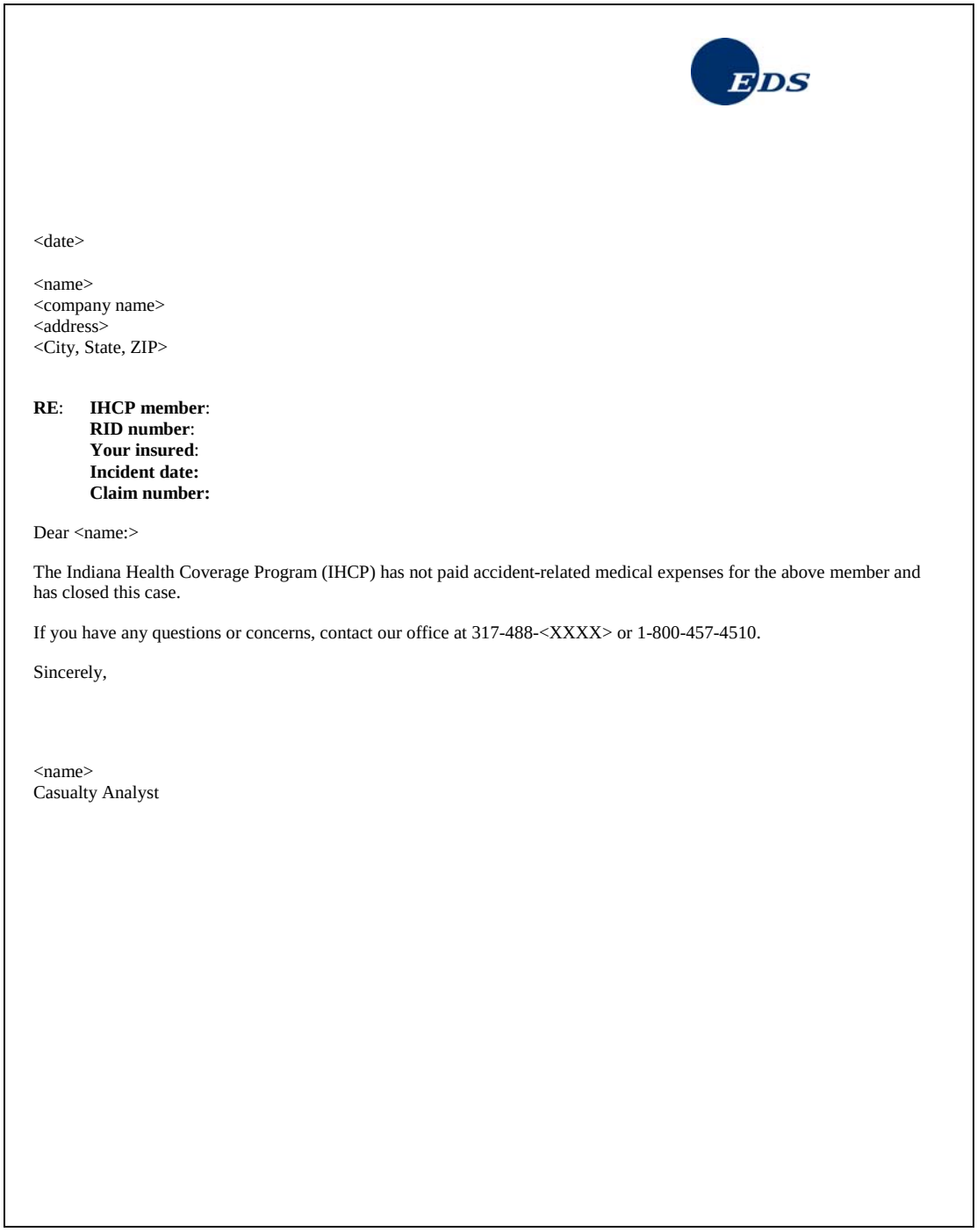
If you have questions or concerns, contact us at 317-488-<XXXX> or 1-800-457-4510.

Sincerely,

<analyst>

Casualty Analyst

Figure 4.14 – Indiana Patient Compensation Fund Notice



<date>

<name>
<company name>
<address>
<City, State, ZIP>

RE: **IHCP member**:
RID number:
Your insured:
Incident date:
Claim number:

Dear <name:>

The Indiana Health Coverage Program (IHCP) has not paid accident-related medical expenses for the above member and has closed this case.

If you have any questions or concerns, contact our office at 317-488-<XXXX> or 1-800-457-4510.

Sincerely,

<name>
Casualty Analyst

Figure 4.15 – No Further Pursuit

<date>
<name>
<address>
<city, state, ZIP>

Re: IHCP member:
RID number:
Incident date:

Dear <name>:

The Indiana Health Coverage Programs (IHCP) received information about a personal injury incident that you were involved in on the above date. Indiana law provides a two-years statute of limitation for filing personal injury claims against a liable third party.

Please provide information about your attorney, your insurance coverage, and the adjuster's name. If you have information about the responsible party provide their insurance information including the adjuster's name and policy number so we can contact them about your medical expenses paid by the IHCP.

If you have any questions, contact us at (317) 488-XXXX or 1-800-457-4510.

Sincerely,

<name>
Casualty Analyst

Figure 4.16 – Pursuit Notice With Statute of Limitations

<date>
<attorney>
<firm>
<address>
<city, state, ZIP code>

RE: Compromise Request
IHCP member:
RID number:
Incident date:
Lien amount:

Dear <name>:

The attorney general's office requires a recommendation from me for proposed lien reductions as mandated in *Pedraza v. Grande, 712 N.E.2d 1007 (Ind. Ct. App. 1999).* The attorney general and the governor must approve any lien compromise based on *Ind. Code § 4-6-2-11*. I will send you an *Amended Notice of Lien* if necessary.

The attorney general's office requires the following supporting documentation prior to reviewing the compromise request:

1. Proposed repayment amount and reason for the compromise request, such as limited liability coverage, comparative fault, or other liability problems
2. File-stamped copy of complaint for damages, if complaint was filed
3. Copy of the police or accident report, if applicable
4. Brief medical records documenting nature and extent of your client's injuries, the treatment received, current medical status and prognosis; and total medical expenses incurred
5. Dollar amount representing full value of your client's injury without regard to comparative fault or limited liability coverage, and documentation supporting the amount considered the full value of client's injury, such as copies of Indiana trial or settlement reports evidencing settlement or jury awards with individuals suffering similar injuries or a *Jury Verdict Research Case Evaluation*
6. Name of all responsible third parties and insurance carriers involved, including any uninsured/underinsured policy held by your client
7. Copy of the declaration sheet listing all available coverage for all applicable insurance policies
8. Amount of settlement or award, including a breakdown of all settlement and award sources, uninsured/underinsured coverage, and medical payments received
9. Copy of settlement agreement reached with the insurance company or defendant
10. Statement of any medical payments received by client from any insurance carrier, the amount received, and source of payment
11. Itemized expenses incurred by your office for this case, accompanied with documents and receipts substantiating the expenses
12. Brief statement of facts of the case, medical treatment, factors resulting in settlement, and basis for the compromise request

If you have any questions or concerns contact me at 317/488-<XXXX>.

Sincerely,

<attorney>

EDS TPL Attorney

Figure 4.17 – Compromise Request

<date>

<attorney>
<name>
<address>
<city, state, ZIP code>

RE: IHCP member:
RID number:
Incident date:

Dear <name>:

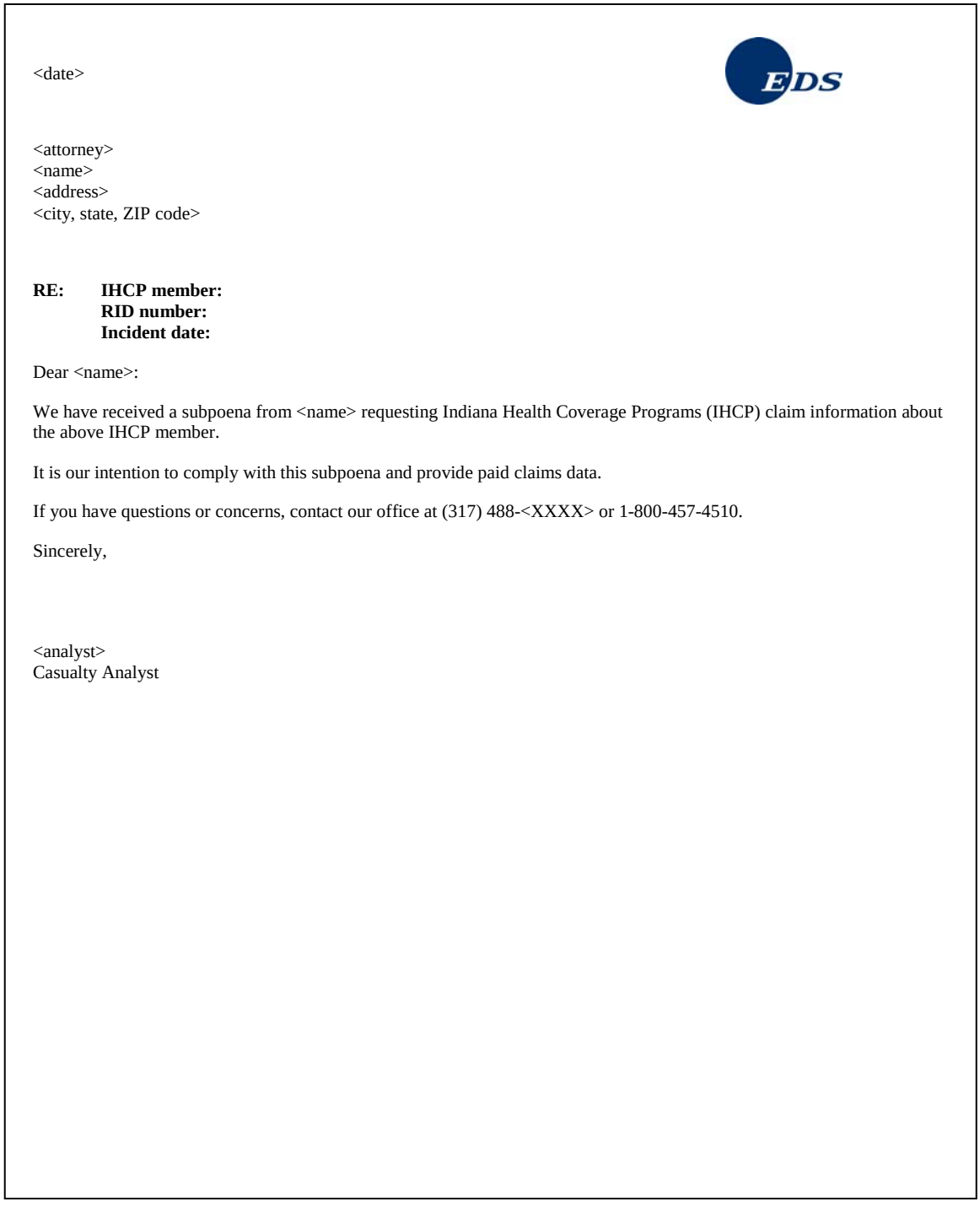
A status update was requested on <date>, along with the anticipated reimbursement date, defendant, and insurance information.

The case will be referred to the attorney general's office for further action if a response is not received within 30 days from the date of this letter.

If you have questions or concerns, contact our office at (317) 488-<XXXX> or 1-800-457-4510.

Sincerely,
<analyst>
Casualty Analyst

Figure 4.18 – Status Update Referral to Attorney General



<date>

<attorney>
<name>
<address>
<city, state, ZIP code>

RE: IHCP member:
RID number:
Incident date:

Dear <name>:

We have received a subpoena from <name> requesting Indiana Health Coverage Programs (IHCP) claim information about the above IHCP member.

It is our intention to comply with this subpoena and provide paid claims data.

If you have questions or concerns, contact our office at (317) 488-<XXXX> or 1-800-457-4510.

Sincerely,

<analyst>
Casualty Analyst

Figure 4.19 – Response to Subpoena for Claim Information

Section 5: Rules and Regulations

Medical Child Support Enforcement

IC 31-14-17 Chapter 17. Expenses of Childbirth

*IC31-14-17-1 Sec.1. T*he court shall order the father to pay at least fifty percent (50 %) of the reasonable and necessary expenses of the mother's pregnancy and childbirth, including the cost of:

(1.) prenatal care;

(2.) delivery;

(3.) hospitalization; and

(4.) postnatal care.

If expenses have been paid by IHCP, the mother and father are jointly and severally liable to reimburse IHCP for the expenses.

The Indiana Code may be accessed on the Internet by accessing www.ai.org/legislative/ic/code.

Basis for the Casualty Compromise Process (Medicaid Law Summary)

Reduction of IHCP Liens

In January of 1996, the Indiana Family and Social Services Administration (FSSA)[fn1] announced that it was no longer going to reduce IHCP subrogation liens pursuant to *I.C. 34-51-2-19 [fn2]*

The impetus for this policy change was a Department of Health and Human Services appeals board decision in which HCFA (now CMS) disallowed approximately $7.5 million in federal financial contribution to the California Medicaid program. The $7.5 million disallowance represented the federal share of the amounts that California would have collected from third-party liability settlements obtained by California Medicaid members during a four-year period if California had not elected to reduce liens pursuant to its lien reduction statute. Apparently, fearing a similar audit and disallowance of federal financial participation, Medicaid took the position that it would no longer reduce Medicaid liens based on *I.C. 34-51-2-9.[fn3]*

After this policy was adopted, plaintiffs' attorneys have sought relief from trial courts by filing petitions for lien reduction. FSSA's primary argument in opposition to lien reduction has been that federal law preempts Indiana's lien reduction statute.

In 1999, the Indiana Court of Appeals rejected the federal preemption argument in two (2) recent decisions: *In The Matter Of The Guardianship Of Stephen Wade [fn4]* and *Pedraza v. Grande [fn5]* In addition, the Indiana legislature bolstered the position taken by the Court of Appeals by amending the IHCP lien statute.*[fn6]*

Senate Enrolled Act No. 133 of 1999 provides in relevant part that:

SECTION 2. IC 12-15-8-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:

Sec. 1. Whenever:

1. the office pays medical expenses for or on behalf of a person who has been injured or has suffered an illness or a disease as a result of the negligence or act of another person; and
2. the injured or diseased person asserts a claim against the other person for damages resulting from the injury, illness, or disease;

on any recovery under the claim, whether by judgment, compromise, or settlement, [the office has a lien against the other person in the amount paid by the office to the extent of the other person's liability for the medical expenses.] [fn7]

Although the amended IHCP lien statute does not specifically state that an IHCP lien is to be reduced because of the uncollectibility of the full value of the IHCP member's third party claim, the Indiana Court of Appeals decisions in *Wade* and *Pedraza* address the situation in which the injured individual is unable to collect the full value of his third party claim.

In re Guardianship Of Wade

711 N.E.2d 851 Ind. Ct. App. (1999)

On April 2, 1994, Stephen Wade was a pedestrian and was hit by a car. The injuries that Wade sustained were severe and permanent and rendered him incapacitated, requiring the appointment of a guardian. By April 1, 1996, IHCP had paid over $200,000.00 toward Wade's medical expenses. The Indiana Family and Social Services Administration [FSSA] filed a notice of its intent to hold a lien in the amount of the monies paid by IHCP against any funds that Wade received for his injuries as a result of contract, judgment or compromise.

Wade's personal injury case was subsequently settled for $100,000.00 (the policy limits of the driver who hit him). Then, his guardian filed a petition to reduce the IHCP lien pursuant to Indiana's lien reduction statute. In support of that petition, Wade's guardian asserted that the value of his personal injury claim exceeded $3 million. Therefore, Wade's guardian asked the court to reduce the amount of the FSSA/IHCP lien to 2.25% - which represented a reduction to 3% of the total lien amount. Wade's guardian also asked that the court order an additional reduction of 25% - to reflect FSSA/IHCP's share of Wade's attorney fees and expenses.

The trial court granted the guardian's motion to reduce the lien. FSSA appealed, asserting that the trial court erred in ordering a reduction of the lien because federal Medicaid law/provisions of the Federal Social Security Act allegedly pre-empt state law/Indiana's lien reduction statute, thus precluding reduction of the IHCP liens. That is, FSSA asserted that the IHCP lien statute [fn8] entitled it to a full recovery of its lien. The Court of Appeals disagreed and affirmed the trial court's order reducing the lien.

The Indiana lien reduction statute [fn9] provides as follows:

If a subrogation lien or other lien or claim that arose out of the payment of medical expenses or other benefits exists in respect to a claim for personal injuries or death and the claimant's recovery is diminished:

1. by comparative fault; or
2. by reason of the uncollectibility of the full value of the claim for personal injuries or death resulting from limited liability insurance or from any other cause;

> The lien or claim shall be diminished in the same proportion as the claimant's recovery is diminished. The party holding the lien or claim shall bear a pro rata share of the claimant's attorney fees and litigation expenses.

FSSA's asserted that the federal Medicaid statute entitles FSSA to full/100% recovery of its IHCP liens. That argument was based upon FSSA's interpretation of the federal Medicaid lien statute as mandating that it seek "full recovery" of medical expenditures from third parties who are responsible for a IHCP member's injuries. The Court of Appeals rejected that interpretation of the federal IHCP lien statute.

The Court of Appeals acknowledged that the federal IHCP lien statute provides a vehicle for FSSA to comply with federal law. However, the Court stated that it reads the federal IHCP lien statute not as mandating full recovery - but rather as requiring "so much of a reimbursement as the State can `reasonably expect to recover'".[fn10] And, in the Court of Appeals' view, "the State's reasonable expectation is subject to the lien reduction statute. Stated differently FSSA is entitled only to that portion of its lien that is not otherwise reduced by the application of Ind.Code 34-51-2-19".[fn11]

The Court of Appeals concluded its opinion by saying that:

"In sum we do not read the lien reduction statute as standing as an obstacle to the accomplishment and execution of the purpose and objectives of the Medicaid statute. Accordingly the trial court did not err in granting Ward's petition to reduce FSSA's Medicaid lien. Judgment affirmed.[fn12]

Pedraza v. Grande

712 N.E.2d 1007 (Ind. Ct. App. 1999)

Antonia Pedraza, a minor, was injured when he was hit by a car being driven by Esther Grande. FSSA and OMPP (the Office of Medicaid Policy and Planning) paid $16,604.91 in medical expenses relative to the treatment that Pedraza required for the injuries that he sustained in the wreck.

Pedraza's parents filed a negligence action Grande. FSSA and OMPP filed a lien for the amount of the medical expenses that they had paid for Pedraza's medical treatment. Because of liability problems,[fn13] the Pedrazas' settled the case against Grande for $19,000.00 [which was approximately 20% of the value of the claim - which was estimated to be approximately $100,000.00]. The settlement was approved by the probate court, and Grande was dismissed from the case.

Before Grande was dismissed, the Pedrazas' filed a motion for declaratory judgment to reduce the IHCP lien by 80%, pursuant to Indiana's lien reduction statute [fn14], on the ground that they had received in settlement only 20% of the value of the case against Grande.

FSSA and OMPP intervened in the lawsuit and argued that the federal IHCP statute does not permit such a reduction and that the lien statute, which provides for a pro rata reduction of medical expenses based upon the claimant's recovery from the tortfeasor, is preempted by the Supremacy Clause. FSSA and OMPP also argued that the IHCP lien statute [fn15] prevails over Indiana's lien reduction statute.

The trial court denied the Pedrazas' request to reduce the IHCP lien, concluding that the proposed pro rata reduction was contrary to Indiana law and that the preemption issue was moot.

On appeal, the Pedrazas' argued that Indiana's lien reduction statute [fn16] required the trial court to reduce the IHCP lien by 80% and that the trial court's determination that the IHCP lien statute supercedes the comparative fault statute is contrary to law. The Pedrazas' asserted that the trial court had a duty to reconcile the two statutes so as to give effect to both. In addition, the Pedrazas' argued that the lien reduction statute was enacted after I.C. 12-1-7-24.6 (which was the almost identical predecessor of the current IHCP lien statute), and that the legislature is presumed to have been aware

of the IHCP lien statute when it enacted the lien reduction statute. The Pedrazas' also argued that if there is an irreconcilable conflict between two statutes, the more recent one controls. In this case, the lien reduction statute is the more recent statute. The Pedrazas' also asserted that the legislature did not intend to deny injured victims any compensation for their injuries while permitting IHCP to retain the total proceeds of any settlement, judgment or insurance policy limits to satisfy its own lien. Finally, the Pedrazas' argued that the lien reduction statute applies to IHCP liens because IHCP liens are not specifically excluded by the lien reduction statute.

The FSSA and OMPP asserted that the lien reduction statute does not apply to IHCP liens, that the IHCP lien statute and the lien reduction statute are inconsistent, and that the IHCP lien statute prevails over the lien reduction statute because the IHCP lien statute applies specifically to IHCP liens while the lien reduction statute applies to medical liens generally. The FSSA and OMPP also contended that the lien reduction statute is preempted by federal IHCP law. They claimed that since the state law conflicted with the federal IHCP law, which requires IHCP to seek full reimbursement of IHCP expenditures for which third parties are responsible, the federal law governs.

The Indiana Trial Lawyers Association filed an amicus curiae brief, in which it argued that:

1. The lien reduction statute is not preempted by federal IHCP law because there is no irreconcilable conflict between federal IHCP legislation and the lien reduction statute.
2. The states are not forbidden by federal law to reduce IHCP liens pursuant to valid state statutes.
3. There is no irreconcilable conflict between the state IHCP statute and the lien reduction statute.
4. Indiana should reduce IHCP liens pursuant to the Indiana Supreme Court's decision in *Department of Public Welfare v. Couch*.[fn17]

The Court of Appeals held that Indiana's lien reduction statute and the IHCP lien statute can be construed to give effect to both. In doing that, the Court of Appeals stated that it concluded that the legislature intended that the FSSA and OMPP have a lien to the extent of IHCP funds expended by the office - except where the claimant's recovery is diminished by comparative fault or by the uncollectibility of the full value of the claim resulting from limited liability insurance or from any other cause. The Court also stated that in such instances (where the claimant's recovery is diminished), the lien is then diminished by the same proportion that the claimant's recovery is diminished. In the present case, since Pedraza's recovery was diminished by 80% due to comparative fault, the Court of Appeals held that IHCP lien should also be reduced by 80%. Therefore, the trial court's judgment was reversed.

Since the *Wade* and *Pedraza* ruling, the FSSA and OMPP have instituted a compromise procedure which gives effect to both the lien reduction statute and IHCP lien statute without the need for the plaintiff's attorney to file a petition for lien reduction with the trial court.

Under this procedure, a IHCP member may request a compromise of a lien held by IHCP. After the plaintiff's attorney provides appropriate documentation of the settlement amount and the value of the case to the IHCP office, the lien is reduced in proportion to the value of the case versus the settlement amount, pursuant to I.C. 34-51-2-19. Additionally, after applying this reduction, the plaintiff's attorney is also entitled to an allowance for attorneys fees and a pro rata share of expenses based on this newly reduced lien amount, pursuant to I.C. 12-15-8-7 and I.C. 12-15-8-8. The plaintiff's attorney is advised of the calculations that the IHCP office is going to recommend, and upon confirmation from the plaintiff's attorney, the IHCP office then makes a recommendation that the lien be compromised.

Since, pursuant to I.C. 4-6-2-11, no lien in favor of the State, shall be compromised without the approval of the Attorney General and the Governor, the OMPP must submit its recommendation to reduce the lien to the Attorney General's office. After receipt by the Attorney General's office, the recommendation is forwarded to the FSSA for review and approval. Following the FSSA's approval, the recommendation is forwarded to the Governor's office for approval. The recommendation is then

returned to the Attorney General's office, where the plaintiff's counsel is notified that the lien has been compromised, and the Attorney General's office then facilitates the collection of the funds due to IHCP under the recommendation.

FOOTNOTES:

[fn1] The Indiana Family and Social Services Administration is the state agency responsible for administering the IHCP program.

[fn2] The lien reduction statute was formerly I.C. 34-4-33-12. It has been recodified and now appears at I.C. 34-51-2-19, and provides that:

> If a subrogation claim or other lien or claim that arose out of the payment of medical expenses or other benefits exists in respect to a claim for personal injuries or death and the claimant's recovery is diminished:
>
> 1. by comparative fault; or
> 2. by reason of the uncollectibility of the full value of the claim for personal injuries or death resulting from limited liability insurance or from any other cause;
>
> the lien or claim shall be diminished in the same proportion as the claimant's recovery is diminished. The party holding the lien or claim shall bear a pro rata share of the claimant's attorney's fees and litigation expenses.

[fn3] However, note the existence of I.C. 12-15-8-7, which provides that:

> If the office recovers money under a lien established by this chapter and the recovery is the result of a claim asserted by an injured, an ill, or a diseased person, the office shall pay the office's pro rata share of all costs reasonably necessary expenses incurred in asserting the claim, including the following:
>
> 1. Deposition costs.
> 2. Witness fees.
> 3. Other costs and expenses.

And I.C. 12-15-8-8, which provides that:

> The office shall pay attorney's fees in the amount of one (1) of the following:
>
> 1. Seven and five-tenths percent (7.5%) of the office's recovery under the lien if the claim was collected without initiating legal proceedings.
> 2. Ten percent (10%) of the office's recovery under the lien if the claim was collected by initiating legal proceedings.

[fn4] (1999) Ind. App., 711 N.E.2d 851.

[fn5] 712 N.E.2d 1007 (Ind. App. 1999).

[fn6] The amendments to I.C. 12-15-8-1 went into effect on July 1, 1999. Prior to the amendments, I.C. 12-15-8-1 provided that IHCP had a lien to the extent of the amount paid by the office to the extent of the other person's liability for the IHCP expenses. The amended statute clearly incorporates comparative fault in the creation of the lien.

[fn7] The words in the prior version of the statute which have been deleted in the new version. New words that were added in the new statute appear in bold print in brackets.

[fn8] I.C. 34-51-2-1.

[fn9] I.C. 34-51-2-19.

[fn10] 711 N.E.2d 851 at 855, citing 42 U.S.C. 1396(a)(25)(B).

[fn11] 711 N.E.2d 851 at 855.

[fn12] 711 N.E.2d 851 at 855.

[fn13] The only witness to the wreck testified under oath that Grande could not have avoided hitting Pedraza because he, without warning, ran out from between two parked cars.

[fn14] I.C. 34-51-2-19.

[fn15] I.C. 12-15-8-1.

[fn16] I.C. 34-51-2-19.

[fn17] (1992) Ind., 605 N.E.2d 165.

Glossary

This glossary defines the universal terms of the Indiana Title XIX program as presented in the Request for Proposals (RFP). The spelling and capitalization is approved by the Office of Medicaid Policy and Planning (OMPP) for use in all documents. Any changes made to the original RFP glossary were made at the request of the OMPP. The terms and definitions in the Indiana Title XIX Common Glossary cannot be changed without contacting the Publications Manager of the Documentation Management Unit who will obtain confirmation and approval from the OMPP. Individual units should include additional terms, as required, in the glossary of their documents.

1115(a) Section of the Social Security Act that allows states to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid program. Radical, system-wide changes are possible under this provision. Waivers must be approved by CMS. See also *Health Care Financing Administration, Waiver*.

11971 State form 11971; see *8A*.

1261A Division of Family and Children State Form 1261A, *Certification – Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility*

1500 This is a claim form used by participating Indiana Health Coverage Programs (IHCP*)* providers to bill medical and medically related services. See also *CMS-1500*.

1902(a)(1) Section of the Social Security Act that requires state Medicaid programs be in effect "in all political subdivisions of the state". See also *Statewide*.

1902(a)(10) Section of the Social Security Act that requires state Medicaid programs provide services to people that are comparable in amount, duration and scope. See also *Comparability; Sections 1915(a), (b), and (c); Waiver.*

1902(a)(23) Section of the Social Security Act that requires state Medicaid programs ensure clients have the freedom to choose any qualified provider to deliver a covered service. See also *Freedom of Choice, Section 1915(b), Waiver.*

1902(r)(2) Section of the Social Security Act that allows states to use more liberal income and resource methodologies than those used to determine Supplemental Security Income (SSI) eligibility for determining Medicaid eligibility.

1903(m) Section of the Social Security Act that allows state Medicaid programs to develop risk contracts with health maintenance organizations or comparable entities. See also *Risk Contracts*.

1915(a) Section of the Social Security Act that states requirements for Medicaid.

1915(b) Section of the Social Security Act that allows states to waive Freedom of Choice. States may require that beneficiaries enroll in HMOs or other managed care programs, or select a physician to serve as their primary care case manager. Waivers must be approved by CMS.

1915(c)	Section of the Social Security Act that allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an ICF-MR, nursing facility or Institution for Mental Disease, or inpatient hospital. Waivers must be approved by CMS. See also *CLASS, HCS, MDCP, CMS, NF, Waiver.*
1915(c)(7)(b)	Section of the Social Security Act that allows states to waive Medicaid requirements to establish alternative, community-based services for individuals with developmental disabilities who are placed in nursing facilities but require specialized services. Waivers must be approved by CMS. See also *CMS, HCS-O, Waiver*.
1929	Section of the Social Security Act that allows states to provide a broad range of home and community care to functionally disabled individuals as an optional state plan benefit. The option can serve only people over 65. In Indiana, individuals of any age may qualify to receive personal care services through Section 1929 if they meet the state's functional disability test and financial eligibility criteria. See also *Home and Community Care.*
450A	Social Evaluation for Long Term Care Admission
450B	Certification by Physician for Long Term Care Services.
590 Program	A State health coverage program for institutionalized persons under the jurisdiction of the Division of Mental Health and Department of Health.
7748	State Form 7748, Medicaid Financial Report
8A	*DPW Form 8A (State Form 11971), Notice to Provider of Member Deductible*. Used to relay member spend-down information to providers when the date of service is the same as the spend-down met date.
AA	Anesthesia Assistant.
AAA	Area Agency on Aging. This agency is a significant element in Home and Community-Based Services Waiver Programs.
AAC	Alternative or Augmentative Communication device.
AAP	American Academy of Pediatrics.
AAS	Atomic absorption spectrophotometer.
ABA	American Banking Association.
ABG	Arterial blood gas.
access	Term used to describe the action of entering and utilizing a computer application.
accommodation charge	A charge used only in institutional claims for bed, board, and nursing care.
accretion	An addition to a file or list. For example: the monthly additions to the Medicare Buy-In List.

ACOG	American College of Obstetricians and Gynecologists.
ACS	Affiliated Computer Services. State Healthcare PBM. Pharmacy Benefits Manager, Drug Rebate Services.
ACSW	Academy of Certified Social Workers.
ADA	American Dental Association.
ADAP	AIDS Drug Assistance Program.
ADC	Adult day care.
adjudicate (claim, credit, adjustment)	To process a claim to pay or deny.
adjustment	(1) A transaction that adjusts and reprocesses a previously processed claim; (2) the contractor adjusts a provider's account by debiting underpayments or crediting overpayments on claims.
adjustment recoupments	Recoupments set up by the adjustments staff on recoup and reprocess transactions. A record of these recoupments is maintained by the Cash Control System until zero balanced.
ADL	Activities of daily living.
Advance Planning Document (APD)	A planning guide the federal government requires when a state is requesting 90 percent funding for the design, development, and implementation of an MMIS.
AFDC	Aid to Families with Dependent Children is replaced by Temporary Assistance to Needy Families (TANF).
AG	Attorney General.
Aged and Medicare-Related Coverage Group	Needy individuals who have been designated by Department of Human Services (DHS) as medical assistance members, who are 65 years old or older, or members under any other category who are entitled to benefits under Medicare.
AHF	Antihemophiliac factor.
aid category	A designation within the State Social Services Department under which a person may be eligible for public assistance and/or medical assistance.
Aid to Families with Dependent Children (AFDC)	Needy families with dependent children eligible for benefits under the Medicaid Program, Title IV-A, Social Security Act. Replaced by Temporary Assistance to Needy Families (TANF).
Aid to the Blind (AB)	A classification or category of members eligible for benefits under the IHCP.
AIDS	Acquired Immune Deficiency Syndrome.
AIM	Advanced Information Management.
ALJ	Administrative Law Judge.

allowed amount	Either the amount billed by a provider for a medical service, the Department's established fee, or the reasonable charge, whichever is the lesser figure.
alpha	A field of only alphabetical letters.
alphanumeric	A field of numbers and letters.
ALS	Advanced life support.
ambulance service supplier	A person, firm or institution approved for and participating in Medicare as an air, ground, or host ambulance service supplier or provider.
amount, duration, and scope	How an IHCP benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state Medicaid plans vary in what is actually covered.
ancillary charge	A charge, used only in institutional claims, for any item except accommodation fees. Examples include drug, laboratory and x-ray charges.
APS	Adult Protective Services.
ARC	Association of Retarded Citizens.
ARCH	Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.
Area Agency on Aging	Also known as AAA. This agency is a significant element in Home and Community-Based Services Waiver Programs.
Area Prevailing Charge	Under Medicare Part B, the charge level that on the basis of statistical data would cover the customary charges made for similar services in the same locality.
ASC	Ambulatory Surgery Center.
AT	Action Team.
Attending Physician	The physician providing specialized or general medical care to a member.
Auditing Contractor	The entity under contract with the Office of Medicaid Policy and Planning (OMPP) to conduct audits of long-term-care facilities or other functions and activities as designated by OMPP.
auto assignment	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
Automated Voice Response (AVR)	Computerized voice response system that helps providers obtain pertinent information concerning member eligibility, benefit limitation, check information, and prior authorization (PA) for those participating in the IHCP.
Average Wholesale Price; used in reference to drug pricing.	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.

AVR	Automated voice-response system used by providers to verify member eligibility by phone.
AWP	Average wholesale price used for drug pricing.
banner page	Brief messages sent to providers with the weekly remittance advices (RAs).
behavorial health care	Assessment and treatment of mental and/or psychoactive substance abuse disorders.
BENDEX	Beneficiary Data Exchange. A file containing data from CMS about persons receiving Medicaid benefits from the Social Security Administration.
Beneficiary	One who benefits from program such as the IHCP. Most commonly used to refer to people enrolled in the Medicare program.
benefit	A schedule of health care service coverage that an eligible participant in the IHCP receives for the treatment of illness, injury, or other conditions allowed by the State.
benefit level	Limit or degree of services a person is entitled to receive based on his or her contract with a health plan or insurer.
bidder	Any corporation, company, organization, or individual that responds to a Request for Proposal (RFP).
bill	A statement of charges for medical services, the submitted claim document, or electronic record; which may contain one or more services performed.
billed amount	The amount of money requested for payment by a provider for a particular service rendered.
billing provider	The party responsible for submitting to the department the bills for services rendered to an IHCP member.
billing service	An entity under contract with a provider that prepares billings on behalf of the provider for submission to payers.
block	Specific area on a claim or worksheet containing claim information.
BLS	Basic Life Support.
Blue Book	The *American Druggist Blue Book*, used as a reference in pricing drug products.
Boren Amendment	An amendment to *OBRA 80 (P.O. 96-499)*, which repealed the requirement that states follow Medicare principles in reimbursing hospitals, nursing facilities (NF) and intermediate care facility for the mentally retarded (ICF/MR) under the IHCP. The amendment substituted language that required states to develop payment rates that were "reasonable and adequate" to meet the costs of "efficiently and economically operated" providers. Boren was intended to give states new flexibility but it has increased successful lawsuits by providers and thus has contributed to the rising cost of Medicaid-funded institutional care.
BQAMIS	Bureau of Quality Assurance Management Information System.
BSN	Bachelor of Science in Nursing.

BSW	Bachelor of Social Work.
budgeted amount	The planned expenditures for a given time period.
bulletins	Informational directives sent to providers of IHCP services containing information on regulations, billing procedures, benefits, processing, or changes in existing benefits and procedures.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible IHCP members, enrolling them in Medicare Part A or Part B or both programs.
C&T	Certification and Transmittal; a document from the Indiana State Department of Health (ISDH).
C519	Authorization for Member Liability Deviation, generated by the Medicaid recipient's county caseworker. Applies only to nursing residents.
cap	A finite limit on the number of certain services for which the department will pay for a given member per calendar year.
capitation	A prospective payment method that pays the provider of service a uniform amount for each person served usually on a monthly basis. Capitation is used in managed care alternatives such as HMOs.
CARF	Commission on Accreditation of Rehabilitation Facilities
carrier	An organization processing Medicare claims on behalf of the federal government.
carve out	A decision to purchase separately a service that is typically a part of an indemnity (a HMO plan). (For example, the behavioral health benefit might be carved out to a specialized vendor to supply these services as stand-alone.)
case management	A process whereby covered persons with specific health care needs are identified and a plan which efficiently uses health care resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner.
case manager	An experienced professional (for example, nurse, doctor or social worker) who works with clients, providers, and insurers to coordinate all necessary services to provide the client with a plan of medically necessary and appropriate health care.
Cash Control Number (CCN)	Financial control number assigned to uniquely identify all refunds or repayments prior to their setup within the cash control system. The batch range within the CCN identifies the type of refund or repayment.
cash control system	Process whereby the case unit creates and maintains the records for accounts receivable, recoupments, and payouts.
categorically needy	All individuals receiving financial assistance under the State's approved plan under Titles I, IV-A, X, XIV, and XVI of the Social Security Act or who are in need under the State's standards for financial eligibility in such plan.
category code	A designation indicating the type of benefits for which an IHCP member is eligible.
category of service	A designation of the nature of the service rendered (for example, hospital outpatient, pharmacy, physician).

CCF	Claim correction form. A CCF is generated by Indiana*AIM* and sent to the provider that submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
CCSW	Certified Clinical Social Worker.
CDC	Centers for Disease Control.
CDFC	County Division of Family and Children.
CDPW	County Department of Public Welfare, which is changed to the County Offices of the Division of Family and Children.
CDT	Current Dental Terminology.
CEO	Chief Executive Officer.
certification	A review of CMS of an operational MMIS in response to a state's request for 75 percent FFP, to ensure that all legal and operational requirements are met by the system; also, the ensuing certification resulting from a favorable review.
certification code	A code PCCM PMPs use to authorize PCCM members to seek services from speciality providers.
CFR	Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.
CHAMPUS	Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS); health-care plan for active duty family members, military retirees and family members of military retirees, now known as TRICARE.
charge center	A provider accounting unit within an institution used to accumulate specific cost data related to medical and health services rendered (for example, laboratory tests, emergency room service, and so forth.).
Children's Special Health Care Services (CSHCS)	State program that provides assistance for children with chronic health problems who are not necessarily eligible for Medicaid.
CHIP	Children's Health Insurance Program.
CI	Continual improvement.
claim	A provider's request for reimbursement of IHCP-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: CMS-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
Claim Correction Form (CCF)	Automatically generated for certain claim errors and sent to providers with the weekly RA. Allows providers the opportunity to correct specified errors detected on the claim during the processing cycle.

claim transaction	Any one of the records processed through the Claims Processing Subsystem. Examples are: (1) Claims (2) Credits (3) Adjustments.
claim type	Three-digit numeric code that refers to the different billing forms used by the program.
claims history file	Computer file of all claims, including crossovers and all subsequent adjustments that have been adjudicated by the MMIS.
claims processing agency	Agency that performs the claims processing function for IHCP claims. The agency may be a department of the single state agency responsible for Title XIX or a contractor of the agency, such as a fiscal agent.
clean claim	Claim that can be processed without obtaining additional information from the provider or from a third party.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
client	A person enrolled in the IHCP and thus eligible to receive services funded through the IHCP.
Cm	Centimeter.
CMHC	Community Mental Health Center.
CMI	Case Mix Index.
CMN	Certificate of Medical Necessity.
CMS	Centers for Medicare and Medicaid Services.
CMS-1500	CMS-approved standardized claim form used to bill professional services. Formerly referred to as HCFA-1500.
COB	Coordination of benefits.
co-insurance	The portion of Medicare-determined allowed charge that a Medicare member is required to pay for a covered medical service after the deductible has been met. The co-insurance or a percentage amount is paid by IHCP if the member is eligible for Medicaid. See also *Cost Sharing*.
Commerce Clearing House Guide	A publication containing Medicaid and Medicare regulations.
Community Living Assistance and Support Services (CLASS)	A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to people with development disabilities other than mental retardation as an alternative to ICF MR VIII institutional care. Administered by Department of Human Services (DHS). See also *ICF MR, 1915(c), Waiver*.
Computer-Output Microfilm (COM)	The product of a device that converts computer data directly to formatted microfilm images bypassing the normal print of output on paper.

concurrent care	Multiple services rendered to the same patient during the same time period.
consent to sterilization	Form used by IHCP members certifying that they give "informed consent" for sterilization to be performed (it must be signed at least 30 days prior to sterilization).
contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
Contractor	Offeror with whom the State successfully negotiated a contract pursuant to *IC 12-1-7-17*. **Auditing Contractor** – The entity under contract with the OMPP to conduct audits of long-term-care facilities or other functions and activities as designated by the OMPP. **Fiscal Agent Contractor** – The offeror(s) with whom the State successfully negotiated a contract to perform one or more business functions associated with claims processing and provider payment activities. **Rate-Setting Contractor** – Entities under contract with the OMPP to perform rate-setting activities for hospitals and long-term-care facilities.
conversion factor	Number that when multiplied by a particular procedure code's relative value units would yield a substitute prevailing charge that could be used when an actual prevailing charge does not exist.
copayment or copay	A cost-sharing arrangement that requires a covered person to pay a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. See also *Cost Sharing*.
core contractor	The successful bidder on *Service Package #1: Claims Processing and Related Services*.
core services	Refers to *Service Package #1: Claims Processing and Related Services.*
COS	Category of Service.
cost settlement	Process by which claims payments to institutional providers are adjusted yearly to reflect actual costs incurred.
cost sharing	The generic term that includes co-payments, coinsurance, and deductibles. Co-payments are flat fees, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a drug prescription. Coinsurance is a percentage share of medical bills (for example, 20 percent) that an insured person must pay out-of-pocket. Deductibles are specified caps on out-of-pocket spending that an individual or a family must incur before insurance begins to make payments.

county office	County offices of Family and Children. Offices responsible for determining eligibility for Medicaid using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by CMS and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible IHCP members subject to the limitations of the *Indiana Administrative Code* (IAC).
CP	Clinical psychologist.
CPAS	Claims processing assessment system. An automated claims analysis tool used by the State for contractor quality control reviews.
CPM	Continuous Passive Motion.
CPS	Child Protective Services.
CPT	Current Procedural Terminology.
CPT Codes (Current Procedural Terminology)	Unique coding structure scheme of all medical procedures approved and published by the American Medical Association.
CPU	Central Processing Unit.
CQM	Continuous quality management.
credit	A claim transaction that has the effect of reversing a previously processed claim transaction.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
Crippled Children's Program	Title V of the Social Security Act allowing states to locate and provide health services to crippled children or children suffering from conditions leading to crippling. Former term for CSHCS.
CRLD	Computer report to laser disk.
CRNA	Certified Registered Nurse Anesthetist.
crossover claim	A claim for services, rendered to a patient eligible for benefits under both Medicaid and Medicare Programs, Titles XVIII and XIX, potentially liable for payment of qualified medical services. (Medicare benefits must be processed prior to IHCP benefits).
CRT Terminal (Cathode-Ray Tube Terminal)	A type of input/output device that may be programmed for file access capabilities, data entry capabilities or both.
CSHCS	Children's Special Health Care Services. A State-funded program providing assistance to children with chronic health problems. CSHCS members do not have to be IHCP-eligible. If they are also eligible for the IHCP, children can be enrolled in both programs.
CSR	Customer Service Request.

CSW	Certified Social Worker
customer	Individuals or entities that receive services or interact with the contractor supporting the IHCP program, including State staff, members, and IHCP providers (managed care PMPs, managed care organizations, and waiver providers).
CVP	Central venous pressure.
D&E	Diagnostic and evaluation (in reference to services and providers).
DASS	Delivery and Support System.
data element	A specific unit of information having a unique meaning.
DC	Doctor of Chiropractic.
DD	Developmentally disabled or developmental disabilities.
DDARS	Division of Disability, Aging, and Rehabilitative Services.
DDE	Direct data entry.
DDS	Doctor of Dental Surgery.
deductible	Fixed amount that a Medicare member must pay for medical services before Medicare coverage begins. The deductible must be paid annually before Part B medical coverage begins; and it must be paid for each benefit period before Part A coverage begins.
DESI	Drug Efficacy Study and Implementation, drug determined to be less than effective (LTE); not covered by the IHCP.
designee	A duly authorized representative of a person holding a superior position.
detail	Information on a claim that denotes a specific procedure or category of certain services and the total charge billed for the procedure(s) involved. Also used to describe lines within a screen segment; for example, those listed to describe periods of eligibility.
development disability	Mental retardation of a related condition. A severe, chronic disability manifested during the developmental period that results in impaired intellectual functioning or deficiencies in essential skills. See also *Mental Retardation, Related Condition.*
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through CMS.
DHS	Department of Human Services.
diagnosis	The classification of a disease or condition. (1) The art of distinguishing one disease from another. (2) Determination of the nature of a cause of a disease. (3) A concise technical description of the cause, nature, or manifestations of a condition, situation, or problem. (4) A code for the above. See also *ICD-9-CM, DRG*.
digit	Any symbol expresses an idea or information, such as letters, numbers, and punctuation.

direct price	Price the pharmacist pays for a drug purchased from a drug manufacturer.
disallow	To determine that a billed service(s) is not covered by the IHCP and will not be paid.
disposition	Application of a cash refund to a previously finalized claim. Also used in processing claims to identify claim finalization—payment or denial.
DME	Durable medical equipment. Examples: wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.
DMH	Division of Mental Health.
DMHA	Division of Mental Health and Addictions.
DO	Doctor of Osteopathy.
DOB	Date of birth.
DOS	Date of service; the specific day services were rendered.
down	Term used to describe the inactivity of the computer due to power shortages or equipment problems. Entries on a terminal are not accepted during down time.
DPOC	Data Processing Oversight Commission. Indiana state agency that oversees agency compliance with all State data processing statutes, policies, and procedures.
DPW	Department of Public Welfare, the previous name of the Family and Social Services Administration
DPW Form 8A	See *8A*.
DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.
drug code	Code established to identify a particular drug covered by the IHCP.
Drug Efficacy Study and Implementation (DESI)	A drug determined to be less than effective (LTE) and not covered by the IHCP.
drug formulary	List of drugs covered by a State Medicaid Program, which includes the drug code, description, strength and manufacturer.
DSH	Disproportionate share hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.
DSM	Diagnostic and Statistical Manual of Mental Disorders; a revision series number is usually associated with the acronym.
DSS	Decision Support System. A data extraction tool used to evaluate IHCP data, trends, and so forth, for the purpose of making programmatic decisions.
dual eligible	A person enrolled in Medicare and Medicaid.

duplicate claim	A claim that is either totally or partially a duplicate of services previously paid.
DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.
E/M	Evaluation and Management.
EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.
ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and personal computers for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECF	Extended care facility; most commonly, long-term care (LTC); or nursing home (NH), or nursing facility (NF).
ECM	Electronic claims management; overall management of claim transmittal via electronic media; related to ECS, EMC, ECC, and paperless claims.
ECS	Electronic claims submission. Claims submitted in electronic format rather than paper. See ***ECC, EMC***.
EDI	Electronic data interchange.
EDP	Electronic data processing.
EDS	Electronic Data Systems Corporation, the IHCP claims processing and third party liability contractor.
EFT	Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
EIP	Early Intervention Program
eligibility file	File containing individual records for all persons who are eligible or have been eligible for the IHCP.
eligible member	Person certified by the State as eligible for medical assistance in accordance with the State Plan(s) under Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, or State law.
eligible providers	Person, organization, or institution approved by the Single State Agency as eligible for participation in the IHCP.
EMC	Electronic media claims. Claims submitted in electronic format rather than paper. See ***ECC, ECS***.
EMS	Emergency medical services.
EOB	Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's remittance advice.

EOMB	Explanation of Medicare benefits. A form provided by Indiana*AIM* and sent to members. The EOMB details the payment or denial of claims submitted by providers for services provided to members. See also *MRN*.
EOP	Explanation of payment, term previously used by the IHCP for the claim summary statement – currently know as a remittance advice (RA). Other insurers continue to use the term for claim statements to providers.
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for IHCP-eligible members younger than 21 years old offering free preventive health care services, such as: screenings, well-child visits, and immunizations. If medical problems are discovered, the member is referred for further treatment.
error code	Code connected to a claim transaction indicating the nature of an error condition associated with that claim. An error code can become a rejection code if the error condition is such that the claim is rejected.
errors	Claims that are suspended prior to adjudication. Several classifications of errors could exist; for example claims with data discrepancies or claims held up for investigation of possible third party liability. Claims placed on suspense for investigatory action can be excluded from classification as an error at the user's option during detail system design. See also *Rejected Claim*.
ESRD	End Stage Renal Disease.
EST	Eastern Standard Time, which is also Indianapolis local time, is a constant in *the majority* of the state of Indiana. This means that from the last Sunday in April to the last Sunday in October Indianapolis is on the same time as the states observing Central Standard Time (CST), like Chicago. From the last Sunday in October to the last Sunday in April Indianapolis is on the same time as the states observing Eastern Standard Time (EST), like New York. This is because Indiana does not observe daylight savings time.
EVS	Eligibility Verification System. A system used by providers to verify member eligibility using a point-of-sale device, on-line PC access, or an automated voice-response system.
exclusions	Illnesses, injuries, or other conditions for which there are no benefits.
Exclusive Provider Organization (EPO)	Arrangement between a provider network and a health insurance carrier or self-insured employer that requires the beneficiary to use only designated providers or sacrifice reimbursement altogether. See also *Preferred Provider Organization.*
Explanation of benefits (EOB)	An explanation of claim denial or reduced payment included on the provider's RA.
Family Planning Service	Any medically approved diagnosis, treatment, counseling, drugs, supplies or devices prescribed or furnished by a physician to individuals of child-bearing age for purposes of enabling such individuals to determine the number and spacing of their children.
FAMIS	Family Assistance Management Information System.

FDB	First DataBank.
Fee-For-Service Reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide. See also *Indemnity Insurance*.
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.
FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.
FFS	Fee-for-service.
FID	Federal Investigation Database.
field audit	A provider's facilities, procedures, records and books are reviewed for conformance to IHCP standards. A field audit may be conducted regularly, routinely, or on a special basis to investigate suspected misutilization.
FIPS	Federal information processing standards.
Fiscal Agent Contractor	The offeror with whom the State successfully negotiated a contract to perform one or more business functions associated with claims processing and provider payment activities.
fiscal month	Monthly time interval in a fiscal year.
Fiscal Year	The designated annual reporting period for an entity: State of Indiana – July 1 through June 30 Federal – October 1 through September 30
FISS	Fiscal intermediary shared system.
flat rate	Reimbursement methodology in which all providers delivering the same service are paid at the same rate. Also known as a Uniform Rate.
FMAP	Federal Medical Assistance Percentage. The percentage of federal dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.
Form 1261A	Division of Family and Children State Form 1261A, *Certification – Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility.*
FPL	Federal poverty level. Income guidelines established annually by the federal government. Public assistance programs usually define income limits in relation to FPL.

FQHC	Federally Qualified Health Center. A center receiving a grant under the Public Health Services Act or entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers, and health care for the homeless. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education, and mental health services.
freedom of choice	A State must ensure that Medicaid beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options.
front end	First process of claim cycle designed to create claim records, perform edits, and produce inventory reports.
front-end process	All claims system activity that occurs before auditing.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the IHCP.
FTE	Full time employee.
FUL	Federal upper limit, the pricing structure associated with maximum allowable cost (MAC) pricing.
GCN*SEQND	Generic code sequence number classification system.
generic drug	A chemically equivalent copy designed from a brand name whose patent has expired and is typically less expensive.
Gm	Gram.
GPCI	Geographic practice cost index.
GPCPD	Governor's Planning Council for People with Disabilities.
GPI	Generic pricing indicator.
Group Model Health Maintenance Organization	A health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.
group practice	A medical practice in which several physicians render and bill for services under a single billing provider number.
hard copy claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as "paper" and "manual".
HBP	Hospital-Based Physician. A physician who performs services in a hospital setting and has a financial arrangement to receive income from that hospital for the services performed.

HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged members to allow them to live in the community and avoid being placed in an institution.
HCE	Health Care Excel, Inc. The IHCP prior authorization, surveillance and utilization review and medical policy contractor
HCFA-1500	CMS-approved standardized claim form used to bill professional services. Now referred to as CMS-1500.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	Healthcare Common Procedure Coding System. A uniform health care procedural coding system approved for use by CMS. HCPCS includes all subsequent editions and revisions.
header	Identification and summary information at the head (top) of a claim form or report.
HealthWatch	Indiana's preventive care program for IHCP members younger than 21 years old. Also known as EPSDT.
HEDIS	Health Plan Employer Data and Information Set. A core set of performance measures developed for employers to use in assessing health plans.
help	An online computer function designed to assist users when encountering difficulties entering a screen.
HHA	Home Health Agency. An agency or organization approved as a home health agency under Medicare and designated by ISDH as a Title XIX home health agency.
HHPD	Hoosier Healthwise for Persons with Disabilities and Chronic Diseases, formerly referred to as MCPD. HHPD is one of three delivery systems in the Hoosier Healthwise managed care program. In HHPD, an MCO is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
HHS	Health and Human Services. U.S. Department of Health and Human Services. Umbrella agency for the Office of Family Assistance, the CMS, the Office of Refugee Resettlement (ORR), and other federal agencies serving health and human service needs.
HIC	Health insurance carrier number.
HIC #	Health Insurance Carrier Number. Identification number for those patients with Medicare coverage. The HIC# is usually the patient's Social Security number and an alphabetic suffix that denotes different types of benefits.
HIO	Health insuring organization.
HIPAA	Health Insurance Portability and Accountability Act

HIPP	Health insurance premium payments.
HIV	Human Immunodeficiency Virus
HMO	Health maintenance organization.
HMO	Health maintenance organization. Organization that delivers and manages health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO suffers losses. If the enrollees cost less, the HMO profits. This gives the HMO incentive to control costs. See also *Sections 1903(m) and 1915 (b), PHP, PPO, Primary Care Case Management.*
HMS	Health Management Services.
Home and Community Care for the Functionally Disabled	An optional state plan benefit that allows states to provide HCBS to functionally disabled individuals (In Indiana, this optional benefit is used by ISDH to provide personal care services to people who have income in excess of SSI limitations but who would be financially qualified in an institution.) Also known as the "Frail Elderly" provision, although Indiana can serve people of any age under this provision. See also *Section 1919, Primary Home Care.*
Home and Community-Based Services-Omnibus Budget Reconciliation Act (HCS-OBRA)	A waiver of the Medicaid state plan granted under Section *1915(c)(7)(b)* of the Social Security Act that allows Indiana to provide community-based services to certain people with developmental disabilities placed in nursing facilities but requiring specialized service according to the PASARR process. See also *Section 1915(c)(7)(b), PASARR, Waiver.*
Home Health Care Services	Visits ordered by a physician authorized by DHS and provided to homebound members by licensed registered and practical nurses and nurses aids from authorized home health care agencies. These services include medical supplies, appliances, and DME suitable for use in the home.
Hoosier Healthwise	Hoosier Healthwise is an IHCP managed care program that consists of two components including Primary Care Case Management (PCCM) and risk-based managed care (RBMC).
HOPA	Hospital outpatient area.
HPB	Health Professions Bureau.
HPSA	Health professional shortage area.
HPSB	Health Professions Service Bureau.
HRI	Health-related items.
HRR	High risk register (in relation to audiological screening).
HSA	Home service agency.
HSPP	Health services provider in psychology.

IAC	*Indiana Administrative Code – Indiana rules.* State government agency administrative procedures.
IC	Indiana Code – Indiana laws.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF	Intermediate care facility. Institution providing health-related care and services to individuals who do not require the degree of care provided by a hospital or skilled nursing home, but who, because of their physical or mental condition, require services beyond the level of room and board.
ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for IHCP-eligible, mentally retarded individuals.
ICHIA	Indiana Comprehensive Health Insurance Association, a health insuring organization for special situations.
ICLPPP	Indiana Childhood Lead Poisoning Prevention Program.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
ICU	Intensive care unit.
IDDARS	Indiana Division of Disability, Aging, and Rehabilitative Services.
IDEA	Individuals with Disabilities Education Act.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IEMS	Indiana Emergency Medical Service.
IEP	Individual Education Program (in relation to the First Steps Early Intervention System).
IFSP	Individual Family Service Plan (in relation to the First Steps Early Intervention System).
IFSSA	Indiana Family and Social Services Administration.
IHCP	Indiana Health Coverage Program.
IMCA	Indiana Motor Carrier Authority.
IMCS	Indiana Motor Carrier Services.

IMD	Institutions for mental disease.
IMF	Indiana Medical Foundation. Non-profit organization contracted by the DHS for the daily review and correction of abstracts submitted by all IHCP hospitals in Indiana.
IMFCU	Indiana Medicaid Fraud Control Unit.
IMRP	Indiana Medical Review Program. Program administered by the IMF to insure the medical necessity of hospitalization and surgery.
indemnity insurance	Insurance product in which beneficiaries are allowed total freedom to choose their health care providers. Those providers are reimbursed a set fee each time they deliver a service. See also *Fee-for-Service*.
Indiana Family and Social Service Administration (IFSSA)	The State agency responsible for the coordination and administration of social service programs in the state of Indiana. The OMPP, under Indiana Family and Social Security Administration (IFSSA), is the single State agency responsible for the administration of the IHCP.
Indiana State Department of Health (ISDH)	The State agency responsible for promotion of health; providing guidance on public health issues; ensuring the quality of health facilities and programs and the administration of certain health programs. The Bureau of Family Health Services is the bureau within the Indiana State Department of Health (ISDH) organization charged with the administration of the Children's Special Health Care Services Division (CSHCS) as well as the Maternal and Child Health Division (MCH) and the Division of Women, Infants, and Children (WIC).
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).
inquiry	Type of online screen programmed to display rather than enter information. Used to research information about members, providers, claims adjustments and cash transactions.
institution	An entity that provides medical care and services other than that of a professional person. A business other than a private doctor or a pharmacy.
intensive care	Level of care rendered by the attending physician to a critically ill patient requiring additional time and study beyond regular medical care.
interim	A billing that is only for a portion of the patient's continuous complete stay in an inpatient setting.
intermediary	Private insurance organizations under contract with the government handling Medicare claims from hospitals, skilled nursing facilities, and home health agencies.
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.

IPA	Individual Practice Associate. Model HMO. A health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.
IPAS	Indiana Pre-Admission Screening.
IPP	Individualized Program Plan..
IRS	Identical, related, or similar drugs, in relation to less than effective (LTE) drugs.
ISBOH	Indiana State Board of Health; currently known as the Indiana State Department of Health.
ISDH	Indiana State Department of Health; previously known as Indiana State Board of Health.
ISETS	Indiana Support Enforcement Tracking System.
ISMA	Indiana State Medical Association.
itemization of charges	A breakdown of services rendered that allows each service to be coded.
ITF	Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language.
Julian Date	A method of identifying days of the year by assigning numbers from 1 to 365 (or 366 on leap years) instead of by month, week, and day. For example, January 10 has a Julian date of 10 and December 31 has a Julian date of 365. This date format is easier and quicker for computer processing.
L	Liter.
LAN	Local area network.
LCL	Lower Control Limit (Pertaining to quality control charts).
LCN	Letter control number.
LCSW	Licensed Clinical Social Worker.
licensed practical nurse	LPN.
limited license practitioner	LLP.
line item	A single procedure rendered to a member. A claim is made up for one or more line items for the same member.
LLP	Limited license practitioner.

LMFT	Licensed Marriage and Family Therapist.
LMHC	Licensed Mental Health Counselor.
LOA	Leave of absence.
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
location	Location of the claim in the processing cycle such as paid, suspended, or denied.
lock-in	Restriction of a member to particular providers, determined as necessary by the State.
lock-out	Restriction of providers, for a time period, from participating in a portion or all of the IHCP due to exceeding standards defined by the department.
LOS	Length of stay.
LPN	Licensed Practical Nurse.
LSL	Lower specification limit, pertains to quality control charts.
LSW	Licensed Social Worker.
LTC	Long-term care. Used to describe facilities that supply long-term residential care to members.
LTE	Less than effective drugs.
M/M	Medicare/Medicaid.
MAC	Maximum allowable charge for drugs as specified by the federal government.
MAC	Monitored anesthesia care
managed care	System where the overall care of a patient is overseen by a single provider or organization. Many state Medicaid programs include managed care components as a method of ensuring quality in a cost efficient manner. See also *Section 1915(b), HMO, PPO, Primary Case Management.*
Managed Care PCCM	Members in the primary care case management delivery system are linked to a primary medical provider (PMP) that acts as a gatekeeper by providing and arranging for most of the members' medical care. The PMP receives an administrative fee per month for every member and is reimbursed on a fee-for-service basis.
Managed Care RBMC	In a risk-based managed care delivery system, the OMPP pays contracted managed care organizations (MCOs) a capitated monthly premium for each IHCP enrollee in the MCOs network. The care of members enrolled in the MCO is managed by the MCO through its network of PMPs, specialists and other providers of care, who contract directly with the MCO.

mandated or required services	Services a state is required to offer to categorically needy clients under a state Medicaid plan. (Medically needy clients may be offered a more restrictive service package.) Mandated services include the following: Hospital (IP & OP), lab/x-ray, nursing facility care (21 and over), home health care, family planning, physician, nurse midwives, dental (medical/surgical), rural health clinic, certain nurse practitioners, federally qualified health centers, renal dialysis services, HealthWatch/EPSDT (under age 21), medical transportation.
manual claim	Claim for services submitted on a paper claim form rather than via electronic means; also seen as *paper* and *hard copy*.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.
MCCA	Medicare Catastrophic Coverage Act of 1988.
MCO	Managed Care Organization. Entity that provides or contracts for managed care. MCOs include entities such as HMOs and Prepaid Health Plans (PHPs). See also *HMO, Prepaid Health Plan*.
MCPD	A pilot program that was available in Marion county from January 1997 through December 1999. It was a voluntary risk-based managed care program for IHCP enrollees that were considered disabled or chronically ill according to the State's established criteria.
MCS	Managed Care Solutions (now called Lifemark Corporation).
MD	Medical Doctor.
MDS	Minimum data set.
Medicaid	A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.
Medicaid certification	The determination of a member's entitlement to Medicaid benefits and notification of that eligibility to the agency responsible for Medicaid claims processing.
Medicaid Financial Report	State Form 7748, used for cost reporting.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
Medicaid plan	See also *Medicaid State Plan, Single State Agency.*
Medicaid Select	A managed care program for the aged, blind and disabled population consisting of a Primary Care Case Management (PCCM) delivery system.
Medicaid State plan	See also *Single State Agency, Medicaid Plan.*
Medicaid-Medicare eligible	Member who is eligible for benefits under both Medicaid and Medicare. Members in this category are *bought-in* for Part B coverage of the Medicare Program by the Medicaid Program.

medical emergency	Defined by the American College of Emergency Physicians as a medical condition manifesting itself by symptoms of sufficient severity that the abscence of immediate medical attention could reasonable be expected to result in: (a) placing health in jeopardy; (b) serious impairment to bodily function; (c) serious dysfunction of any bodily organ or part; or (d) development or continuance of severe pain.
medical necessity	The evaluation of health care services to determine if they are: medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with national medical practice guidelines regarding type, frequency and duration of treatment.
medical policy	Portion of the claim processing system whereby claim information is compared to standards and policies set by the state for the IHCP.
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
medical supplies	Supplies, appliances, and equipment.
medically needy	Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan, but are insufficient to meet their costs of health and medical services.
Medicare	The federal medical assistance program described in Title XVIII of the Social Security Act for people over the age of 65, for persons eligible for Social Security disability payments and for certain workers or their dependents who require kidney dialysis or transplantation.
Medicare crossover	Process allowing for payment of Medicare deductibles and/or co-insurance by the Medicaid program.
Medicare deductibles and co-insurance	All charges classified as deductibles and/or coinsurance under Medicare Part A or Part B for services authorized by Medicare Part A or Part B.
member	A person who receives a IHCP service while eligible for the IHCP. People may be IHCP-eligible without being IHCP members. These individuals are called enrollees or members when in the Hoosier Healthwise Progam. See also *Client, Eligible Member*.
member relations	The activity within the single state agency that handles all relationships between the IHCP and individual member.
member restriction	A limitation or review status placed on a recipient that limits or controls access to the IHCP to a greater extent than for other nonrestricted members.
mental disease	Any condition classified as a neurosis, psychoneurosis, psychopathy, psychosis, or personality disorder.
mental illness	A single severe mental disorder, excluding mental retardation, or a combination of severe mental disorders as defined in the latest edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders*.

mental retardation	Significantly subaverage intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.
menu	Online screen displaying a list of the available screens and codes needed to access the online system.
MEQC	Medicaid eligibility quality control.
MFCU	Medicaid Fraud Control Unit.
MHS	Managed Health Services.
MI	Mental illness.
MI/DD	Mental illness and developmental disability.
microfiche	Miniature copies of the RAs that can store approximately 200 pages of information on a plastic sheet about the size of an index card.
microfilm	Miniature copies of all claims received by Medicaid stored on film for permanent records-keeping and referral.
misutilization	Any usage of the IHCP by any of its providers or members not in conformance with both state and federal regulations, including both abuse and defects in level and quality of care.
Ml	Milliliter.
MLOS	Mean Length of Stay.
MMDDYY	Format for a date to be reflected as month, day, and year such as 091599.
MMIS	Medicaid Management Information System. Indiana's current MMIS is referred to as Indiana*AIM.*
MMRT	Medicaid Medical Review Team.
MOC	Memorandum of Collaboration; a Hoosier Healthwise document that provides a formal description of the terms of collaboration between the primary medical provider (PMP) and the preventive health care service provider (PHCSP). It also serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.
MOC	Memoranda of Collaboration. For example, a Hoosier Healthwise document that provides a formal description of the terms of collaboration between a PMP and PHCSP, and serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.
module	A group of data processing and/or manual processes that work in conjunction with each other to accomplish a specific function.
MR/DD	Mental retardation and developmentally disabled.

MRN	Medicare Remittance Notice. A form provided by Indiana*AIM* and sent to members. The MRN details the payment or denial of claims submitted by providers for services provided to members.
MRO	Medicaid Rehabilitation Option. Special program restricted to community mental health centers for persons who are seriously mentally ill or seriously emotionally disturbed.
MRT	Medical Review Team, unit which makes decision regarding Disability Determination.
MS	Mail stop.
MSN	Master of Science in Nursing.
MSS	Master of Social Sciences.
MSW	Master of Social Work.
MWU	Medicaid Waiver Unit, the IDDARS unit which manages the HCBS Waiver Programs.
NAS	Non-ambulatory service.
NASW	National Association of Social Workers.
NCPDP	National Council for Prescription Drug Programs.
NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.
NDDF	National Drug Data File.
NEC	Not elsewhere classified.
NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to on-line, real-time eligibility information.
Network Model HMO	An HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multi-specialty groups. The physician works out of his or her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.
NF	Nursing facility; also seen as ECF, NH, and LTC.
NH	Nursing home; also seen as ECF, NF, and LTC.
NIH	National Institutes of Health.
NOC	Not otherwise classified.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.

non-core services	Refers to *Service Packages #2 and #3*.
NOOH	Notice of Opportunity for Hearing. Notification that a drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the *Federal Register* on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications.
NPIN	National provider identification number.
nursing facilities	Facilities licensed by and approved by the state in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) Long Term Care Program. See also *Long Term Care, TILE.*
nursing facility waiver (NF waiver)	A waiver of the Medicaid's state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to adults as an alternative to nursing facility care. See also *Nursing Facilities, 1915(c), Waiver*.
OASDI	Old Age, Survivors and Disability Insurance. See also *Title II Benefits (Social Security or OASDI).*
OB/GYN	Obstetrician/Gynecologist.
OBRA	Omnibus Budget Reconciliation Act.
OBRA-90	Omnibus Budget Reconciliation Act of 1990.
OCR	Optical Character Recognition Equipment. A device that reads letters or numbers from a page and converts them to computerized data, bypassing data entry.
OD	Doctor of Optometry.
OFC	Office of Family and Children.
OIG	Office of the Inspector General.
OMNI	A point-of-sale device used by providers to scan member ID cards to determine eligibility.
OMPP	Office of Medicaid Policy and Planning.
optional services or benefits	More than 30 different services that a state can elect to cover under a state Medicaid plan. Examples include personal care, rehabilitative services, prescribed drugs, therapies, diagnostic services, ICF-MR, targeted case managed, and so forth.
OTC	Over the counter, in reference to drugs.
other insurance	Any health insurance benefits that a patient might possess in addition to Medicaid or Medicare.
other processing agency	Any organization or agency that performs IHCP functions under the direction of the single state agency. The single state agency may perform all IHCP functions itself or it may delegate certain functions to other processing agencies.

outcome measures	Assessments that gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity, and health status.
outcomes	Results achieved through a given health care service, prescription drug use, or medical procedure.
outcomes management	Systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement, then remeasuring and remodifying, often in a formal program of continuous quality improvement.
outcomes research	Studies aimed at measuring effect of a given product, procedure, or medical technology on health or costs.
outlier	An additional payment made to hospitals for certain clients under age 21 for exceptionally long or expensive hospital stays.
out-of-state	Billing for a IHCP member from a facility or physician outside Indiana or from a military facility.
outpatient services	Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.
overpayment	An amount included in a payment to a provider for services provided to a IHCP member resulting from the failure of the contractor to use available information or to process correctly.
override	Forced bypassing of a claim due to error (or suspected error), edit, or audit failure during claims processing. Exempted from payment pending subsequent investigation not to be in error.
overutilization	Use of health or medical services beyond what is considered normal.
PA	Prior authorization. Some designated IHCP services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
paid amount	Net amount of money allowed by the IHCP.
paid claim	Claim that has had some dollar amount paid to the provider, but the amount may be less than the amount billed by the provider.
paid claims history file	History of all claims received by IHCP that have been handled by the computer processing system through a terminal point. Besides keeping history information on paid claims, this file also has records of claims that were denied.
paper claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as *hard copy* and *manual*.
paperless claims	Claims sent by electronic means; equivalent to EMC, ECS, ECC, and similar terms denoting claim transmittal via electronic media.
parameter	Factor that determines a range of variations.

Part A	Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency or hospice care by a licensed and certified hospice agency. See also *Medicare, Beneficiary*.
Part B	Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy, and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. See also *Medicare, SMIB, Buy-In*.
participant	One who participates in the IHCP as either a provider or a member of services.
participating members	Individuals who receive Title XIX services during a specified period of time.
participating providers	Providers who furnish Title XIX services during a specified period of time.
participation agreement	A contract between a provider of medical service and the state that specifies the conditions and the services the facility must provide to serve IHCP members and receive reimbursement for those services.
PAS	Pre-admission screening. A nursing home and community-based services program implemented on January 1, 1987, that is designed to screen a member's potential for remaining in the community and receiving community-based services as an alternative to nursing home placement.
PAS Form 4B	Pre-Admission Screening Notice of Assessment Determination form.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.
payouts	Generate payments to providers for monies owed to them that are not claim related. Payouts are done as the result of cost settlements or to return excess refunds to the provider.
PC	Personal computer.
PCA	Physician's Corporation of America. An HMO providing health benefits to Medicaid clients.
PCCM	Members in the Primary Care Case Management delivery system are linked to a primary medical provider (PMP) that acts as a gatekeeper by providing and arranging for most of the members' medical care. The PMP receives an administrative fee per month for every member and is reimbursed on a fee-for-service basis.
PCN	Primary care network.
PCP	Primary Care Provider.

PCP	Primary care physician. A physician the majority of whose practice is devoted to internal medicine, family/general practice, and pediatrics. An obstetrician/gynecologist may be considered a primary care physician.
PDD	Professional data dimensions.
PDR	Provider Detail Report/Provider Desk Review.
peer	A person or committee in the same profession as the provider whose claim is being reviewed.
peer review	An activity by a group or groups of practitioners or other providers, by which the practices of their peers are reviewed for conformance to generally-accepted standards.
PEN	Parenteral and enteral nutrition .
pending (claim)	Action of postponing adjudication of a claim until a later processing cycle.
per diem	Daily rate charged by institutional providers.
performing provider	Party who actually performs the service/provides treatment.
PERS	Personal emergency response system, an electronic device which enables the consumer to secure help in an emergency.
personal care	Optional Medicaid benefit that allows a state to provide attendant services to assist functionally impaired individuals in performing the activities of daily living (for example, bathing, dressing, feeding, grooming). Indiana provides Primary Home Care Services under this option. See also *Primary Home Care*.
PET	Positron Emission Tomography.
PGA	Peer group average.
PHC	Primary home care. IHCP-funded community care that provides personal care services to over 40,000 aged or disabled people in Indiana. PHC is provided as an optional state plan benefit. See also *Personal Care*.
PHCSP	Preventive health care services provider; a provider of well-child care, pre-natal care services, or care coordination services.
PHO	Physician hospital organization.
PHP	Prepaid health plan. A partially capitated managed care arrangement in which the managed care company is at risk for certain outpatient services. See also *VISTA*.
physician hospital organization	An organization whose board is composed of physicians, but with a hospital member, formed for the purpose of negotiating contracts with insurance carriers and self-insured employers for the provision of health care services to enrollees by the hospital and participating members of the hospital's medical staff.
PKU	Phenylketonuria.

Plan of Care	A formal plan developed to address the specific needs of an individual. It links clients with needed services.
PM/PM	Per member per month. Unit of measure related to each member for each month the member was enrolled in a managed care plan. The calculation is as follows: # of units/member months (MM).
PMF	Provider master file.
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to IHCP members assigned to the PMP's care.
pool (risk pool)	A defined account (for example, defined by size, geographic location, claim dollars that exceed **x** level per individual, and so forth) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities of a given defined account as well as required funding to support the claim liability.
POS	Place of service or point of sale, depending on the context.
PPO	Preferred provider organization. An arrangement between a provider network and a health insurance carrier or a self-insured employer. Providers generally accept payments less than traditional fee-for-service payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given strong financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care. See also *Exclusive Provider Organization (EPO).*
PR	Provider relations.
practitioner	An individual provider. One who practices a health or medical service profession.
Premium	Due from member in order to be eligible for Package C.
pre-payment review	Provider claims suspended temporarily for dispositioning and manual review by the HCE SUR Unit.
prescription medication	Drug approved by the FDA that can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.
preventive care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care.
pricing	Determination of the IHCP allowable.
primary care	Basic or general health care traditionally provided by family practice, pediatrics, and internal medicine.
prime contractor	Contractor who contracts directly with the State for performance of the work specified.
print-out	Reports and information printed by the computer on data correlated in the computer's memory.

prior authorization	An authorization from the IHCP for the delivery of certain services. It must be obtained prior to the service for benefits to be provided within a certain time period, except in certain allowed instances. Examples of such services are abortions, goal-directed therapy, and EPSDT dental services.
Prior Authorization or Prior Review and Approval	The procedure for the office's prior review and authorization, modification, or denial of payment for covered medical services and supplies within IHCP allowable charges. It is based on medical reasonableness, necessity, and other criteria as described in the *IAC Covered Services Rule* and *Medical Policy Rule* found in the *Appendix* to this manual.
private trust	Trust fund available to pay medical expenses.
PRO	Peer review organization.
procedure	Specific, singular medical service performed for the express purpose of identification or treatment of the patient's condition.
procedure code	A specific identification of a specific service using the appropriate series of coding systems such as the CDT, CPT, HCPCS, or ICD-9-CM.
processed claim	Claim where a determination of payment, nonpayment, or pending has been made. See also *Adjudicated Claim*.
Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities necessary to meet all federal Pro-DUR requirements and all DUR requirements.
profile	Total view of an individual provider's charges or a total view of services rendered to a member.
program director	Person at the contractor's local office who is responsible for overseeing the administration, management, and daily operation of the MMIS contract.
prosthetic devices	Devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ or limb.
provider	Person, group, agency, or other legal entity that is enrolled as a provider of services and provides a covered IHCP service to an IHCP member.
Provider Agreement	A contract between a provider and the OMPP setting out the terms and conditions of a provider's participation in the IHCP. It must be signed by the provider prior to any reimbursement for providing covered services to members.
provider enrollment application	Required document for all providers who provide services to IHCP members.
provider manual	Primary source document for IHCP providers.
provider networks	Organizations of health care providers that service managed care plans. Network providers are selected with the expectation they deliver care inexpensively, and enrollees are channeled to network providers to control costs.
provider number	Unique individual or group number assigned to practitioners participating in the IHCP.

provider relations	Function or activity within that handles all relationships with providers of health care services.
provider type	Classification assigned to a provider such as hospital, doctor or dentist.
PSRO	Professional standards review organization.
purged	Claims are removed from history files according to specific criteria after 36 months from the claim's last financial date. Claims data is online for up to 36 months.
QA	Quality assurance.
QARI	Quality Assurance Reform Initiative. Guidelines established by the federal government for quality assurance in Medicaid managed care plans.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QM	Quality management.
QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.
QMHP	Qualified mental health professional.
QMRP	Qualified mental retardation professional.
quality improvement	A continuous process that identifies problems in health care delivery, tests solutions to those problems, and constantly monitors the solutions for improvement.
QUCR	Quarterly Utilization Control Reports.
query	An inquiry for specific information not supplied on standardized reports.
RA	Remittance advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
Rate-Setting Contractor	An entity under contract with the OMPP to perform rate-setting activities.
RBA	Room and Board Assistance.
RBMC	In a risk-based managed care delivery system, the OMPP pays contracted managed care organizations (MCOs) a capitated monthly premium for each IHCP enrollee in the MCOs network. The care of members enrolled in the MCO is managed by the MCO through its network of PMPs, specialists and other providers of care, who contract directly with the MCO.

RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
reasonable charge	Charge for health care services rendered that is consistent with efficiency, economy, and quality of the care provided, as determined by the OMPP.
reasonable cost	All costs found necessary in the efficient delivery of needed health services. Reasonable cost is the normal payment method for Medicare Part A.
recidivism	The frequency of the same patient returning to a provider with the same presenting problems. Usually refers to inpatient hospital services.
Red Book	Listing of the average wholesale drug prices.
referring provider	Provider who refers a member to another provider for treatment service.
regulation	Federal or state agency rule of general applicability designed and adopted to implement or interpret law, policy, or procedure.
reimbursement	Payment made to a provider, pursuant to Federal and State law, as compensation for providing covered services to members.
reinsurance	Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents. See also *Stop-Loss Insurance.*
rejected claim	Claim determined to be ineligible for payment to the provider, contains errors, such as claims for noncovered services, ineligible provider or patient, duplicate claims, or missing provider signature. Returned to the responsible provider for correction and resubmission prior to data entry into the system.
related condition	Disability other than mental retardation which manifests during the developmental period (before age 22) and results in substantial functional limitations in three of six major life activities (for example, self-care, expressive/receptive language, learning, mobility, self-direction, and capacity for independent living). These disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and a host of other diagnoses, are said to be related to mental retardation in their effect upon the individual's functioning.
remittance advice (RA)	Comprehensive billing information concerning the member disposition of a provider's submitted IHCP claims.
Remittance and Status Report (R/A)	A computer report generated weekly to a provider to inform the provider about the status of finalized and pending claims. The R/A includes EOB codes that describe the reasons for claim cutbacks, and denials. The provider receives a check enclosed in the R/A when claims are paid.
rendering provider	A provider employed by a clinic or physician group that provides service as an employee. The employee is compensated by the group and therefore does not bill directly.
rep	Provider relations representative.

repayment receivables	Transaction established in the Cash Control System when a provider has received payment to which he was not entitled.
report item	Any unit of information or data appearing on an output report.
required field	Screen field that must be filled to display or update desired information.
resolution	Step taken to correct an action that caused a claim to suspend from the system.
resolutions	The area within the processing department responsible for edit and audit correction.
Retro-DUR	Retrospective Drug Utilization Review.
RFI	Request for Information.
RFP	Request for Proposals.
RHC	Rural health clinic
RID	Recipient Identification (ID) number; the unique number assigned to a member who is eligible for IHCP services.
risk contract	An agreement with an MCO to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense or degree. See also *MCO, Pool, Risk Pool*.
RN	Registered Nurse.
RNC	Registered Nurse Clinician.
route	Transfer of a claim to a certain area for special handling and review.
routine	A condition that can wait for a scheduled appointment.
RPT	Registered physical therapist.
RPTS	Research Project Tracking System.
RR	Resident review.
RUG	Resource Utilization Group.
rural health clinic	Any agency or organization that is a rural health clinic certified and participating under Title XVIII of the Social Security Act and has been designated by DHS as a Title XIX rural health clinic.
RVS	Relative value study. A procedure coding structure for all medical procedures, based on the most common procedure used, that assigns relative value units to medical procedures according to the degree of difficulty.
RVU	Relative value unit.
SA/DE	State Authorization/Data Entry.
SBOH	State Board of Health; previous term for the State Department of Health.
SCP	Specialty care physicians.

screening	The use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who have a disease or abnormality and to identify those in need of more definitive examination or treatment.
SD	Standard deviation.
SDA	Standard dollar amount.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
SED	Seriously emotionally disturbed.
SEH	Seriously emotionally handicapped.
selective contracting	Option under Section *1915(b)* of the Social Security Act that allows a state to develop a competitive contracting system for services such as inpatient hospital care.
SEPG	Software Engineering Process Group.
service date	Actual date on which a service(s) was rendered to a particular member by a particular provider.
service limits	Maximum number of service units to which a member is entitled, as established by the IHCP for a particular category of service. For example, the number of inpatient hospital days covered by the IHCP might be limited to no more than 30 days.
SG	Steering group.
shadow claims	Reports of individual patient encounters with a managed care organization's (MCOs) health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.
SI/IS	Severity of illness/intensity of services.
SIPOC	System map outlining suppliers, inputs, processes/functions, outputs, and customers.
SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
SMI	Severely mentally ill.
SMI	Supplemental medical insurance, Part B of Medicare.
SNF	Skilled nursing facility.
SOBRA	Sixth Omnibus Budget Reconciliation Act.
SOBRA	Omnibus Budget Reconciliation Act of 1986.

SPC	Statistical process control.
special vendors	Provide support to IHCP business functions but the vendors are not currently Medicaid fiscal agents.
specialty	Specialized practice area of a provider.
specialty certification	Certification or approval by professional academy, association, or society that designates this provider has demonstrated a given level of training or competence and is a fellow or specialist.
specialty vendors	Provide support to IHCP business functions but the vendors are not currently IHCP fiscal agents.
spend-down	Process whereby IHCP eligibility may be established if an individual's income is more than that allowed under the State's income standards and incurred medical expenses are at least equal to the difference between the income and the medically needy income standard.
SPMI	Severe and persistent mental illness.
SPR	System performance review.
SSA	Social Security Administration of the federal government.
SSCN	Social security claim number. Account number used by SSA to identify the individual on whose earnings SSA benefits are being paid. It is a social security account number followed by a suffix, sometimes as many as three characters, designating the type of beneficiary (for example, wife, widow, child, and so forth). The SSCN is the number that must be used in the Buy-In program. A beneficiary can have his own SSN but be receiving benefits under a different claim number.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
SSN	Social Security Account Number. The number used by SSA throughout a wage earner's lifetime to identify his or her earnings under the Social Security Program. This account number consists of nine figures generally divided into three hyphenated sets, such as 000-00-0000. The account number is commonly known as the Social Security Number. The number is not to be confused with Social Security Claim Number.
SSP	State Supplement Program. State-funded program providing cash asssistance that supplements the income of those aged, blind, and disabled individuals who are receiving SSI (or who, except for income or certain other criteria, would be eligible for SSI).
SSRI	Selective Serotonin Re-uptake Inhibitor.
Staff Model HMO	Health care model that employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.
standard business	Health care business within the private sector of the industry, such as Blue Cross and Blue Shield.

State	Spelled as shown, State refers to the state of Indiana and any of its departments or agencies.
State fiscal year	A 12-month period beginning July 1 and ending June 30.
State Form 11971	See *8A.*
State Form 7748	Medicaid Financial Report, used for cost reporting.
State Medicaid Office	Office of Medicaid Policy and Planning, within the Family and Social Services Administration, responsible for administering the IHCP in Indiana.
State Plan	The medical assistance plan of Indiana as approved by the Secretary of Health, Education and Welfare in accordance with provisions of Title XIX of the Social Security Act, as amended.
status	Condition of a claim at a given time; such as paid, pended, denied, and so forth.
stop-loss insurance	Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance: (1) Specific or individual-reimbursement is given for claims on any covered individual which exceed a predetermined deductible, such as $25,000 or $50,000; (2) Aggregate-reimbursement is given for claims which in total exceed a predetermined level, such as 125 percent of the amount expected in an average year. See also *Reinsurance*.
subcontractor	Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.
submission	The act of a provider sending billings to EDS for payment.
subsystem	A Medicaid term that refers to one of the following (I)HIS processing components: member's subsystem, provider subsystem, claims processing subsystem, reference file subsystem, surveillance and utilization review subsystem, and management and administrative reporting subsystem.

SUR Surveillance and Utilization Review. Refers to system functions and activities mandated by the Centers for Medicare and Medicaid Services (CMS) that are necessary to maintain complete and continuous compliance with CMS regulatory requirements for SUR including the following SPR requirements:

1. Statistical analysis
2. Exception processing
3. Provider and member profiles
4. Retrospective detection of claims processing edit and audit failures and errors
5. Retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards
6. Retrospective detection of fraud and abuse by providers or members
7. Sophisticated data and claim analysis including sampling and reporting
8. General access and processing features
9. General reports and output

Survey Agency The ISDH is the designated survey agency responsible for surveying, monitoring, reviewing, and certifying institutional providers of service who request or agree to participate in the IHCP. The ISDH also certifies several other provider types. These types are discussed under the section titled; *State, County Contractor Responsibilities* included in this chapter.

suspended transaction A suspended transaction requires further action before it becomes a paid or denied transaction, usually because of the presence of error(s).

suspense file Computer file where various transactions are placed that cannot be processed completely, usually because of the presence of an error condition(s).

systems analyst or engineer Responsible for performing the following activities:

1. Detailed system and program design
2. System and program development
3. Maintenance and modification analysis and resolution
4. User needs analysis
5. User training support
6. Development of personal IHCP knowledge

TANF Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children.

TBI Traumatic brain injury.

TEFRA Tax Equity and Fiscal Responsibility Act of 1982. The federal law which created the current risk and cost contract provisions under which health plans contract with CMS and which define the primary and secondary coverage responsibilities of the Medicare program.

TEFRA 134(a) Provision of the Tax Equity and Fiscal Responsibility Act of 1982 that allows states to extend Medicaid coverage to certain disabled children.

therapeutic classification Code assigned to a group of drugs that possess similar therapeutic qualities.

third party	An individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of an applicant for, or member of, medical assistance under Title XIX.
third-party resource	A resource available, other than from the department, to an eligible member for payment of medical bills. Includes, but is not limited to, health insurance, workmen's compensation, liability, and so forth.
Title I	The Old Age Assistance Program that was replaced by the Supplemental Security Income program (SSI).
Title II	Old Age, Survivors and Disability Insurance Benefits (Social Security or OASDI).
Title IV-A	AFDC, WIN Social Services.
Title IV-B	Child Welfare.
Title IV-D	Child Support.
Title IV-E	Foster Care and Adoption.
Title IV-F	Job Opportunities and Basic Skills Training.
Title V	Maternal and Child Health Services.
Title X	Aid to the Blind program (AB) replaced by the SSI.
Title XIV	Permanently and Totally Disabled program (PTD) replaced by the SSI.
Title XIX	Provisions of Title 42, United States code Annotated Section 1396-1396g, including any amendments thereto.
Title XIX Hospital	Hospital participating as a hospital under Medicare, that has in effect a utilization review plan (approved by DHS) applicable to all recipients to whom it renders services or supplies, and which has been designated by DHS as a Title XIX hospital; or a hospital not meeting all of the requirements of Subsection A.5.1.0.0.0 of the RFP but that renders services or supplies for which benefits are provided under Section 1814 (d) of Medicare or would have been provided under such section had the recipients to whom the services or supplies were rendered been eligible and enrolled under part A of Medicare, to the extent of such services and supplies only, and then only if such hospital has been approved by DHS to provide emergency hospital services and agrees that the reasonable cost of such services or supplies, as defined in Section 1901 (a) (13) of title XIX, shall be such hospital's total charge for such services and supplies.
Title XV	ISSI.
Title XVI	The SSI.
Title XVIII	The Medicare Health Insurance program covering hospitalization (Part A) and medical insurance (Part B); the provisions of Title 42, United States Code Annotated, Section 1395, including any amendments thereto.
TPL	Third Party Liability. A client's medical payment resources, other than Medicaid, available for paying medical claims. These resources generally consist of public and private insurance carriers.

TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services.*
TPN	Total Parenteral Nutrition.
TQM	Total Quality Management.
trend	Measure of the rate at which the magnitude of a particular item of date is changing.
TRICARE	Formerly known as the Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS); health-care plan for active duty family members, military retirees, and family members of military retirees.
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UCL	Upper control limit, pertaining to quality control charts.
UCR	Usual, customary, and reasonable charge by providers to their most frequently billed nongovernmental third party payer.
UM	Utilization management.
unit of service	Measurement divisions for a particular service, such as one hour, one-quarter hour, an assessment, a day, and so forth.
UPC	Universal product code. Codes contained on the first data bank tape update or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
UR	Utilization Review. A formal assessment of the medical necessity, efficiency, or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
urgent	Defined as a condition not likely to cause death or lasting harm, but for which treatment should not wait for the next day or a scheduled appointment.
user	Data processing system customer or client.
USL	Upper specification limits, pertaining to quality control charts.
USPHS	United States Public Health Service.
utilization	The extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for the services.
utilization management	Process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.
VA	Veterans Administration.

VFC	Vaccines for Children program.
VIP	Validation Improvement Plan.
VRS	Voice Response System, primarily seen as AVR, automated voice response system.
WAN	Wide area network.
waiver	Waiver allows members to move from the traditional Medicaid environment to a less restrictive environment. Some of the statutory entitlements are waved for the member.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children younger than five years old.
workmen's compensation	A type of third-party liability for medical services rendered as the result of an on-the-job accident or injury to an individual for which his employer's insurance company may be obligated under the Workman's Compensation Act.
Y2K	Year 2000. Commonly used in computer system compliance issues.

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